Executive Summary
HRSA-Hospital Bioterrorism Preparedness and Planning Program
Work Plan

Purpose
The Washington State Department of Health (DOH) is submitting a work plan for approval by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services for funding to upgrade the preparedness of Washington's hospitals and collaborating entities to respond to bioterrorism. The primary focus of this first stage of the funding is assessment and planning. Ultimately, Washington will have a hospital system capable of responding to acts of bioterrorism, other outbreaks of infectious disease, public health threats and emergencies.

Background
The Health Resources and Services Administration will provide Washington State $2,553,418 in order to improve the capacity of hospitals to work with local health jurisdictions and other components of the health care system to respond to bioterrorist attack or other large scale public health emergency. These funds will be used for state, regional and local planning with hospitals, local health jurisdictions, emergency management, and emergency medical services (EMS.) The goal is to improve our ability to work together in response to biological terrorist events or other outbreaks of infectious disease. Following completion of a needs assessment, the prime objective will be development and implementation of bioterrorism plans and protocols for hospitals and other participating health care entities.

Approach
The proposed work plan will ensure the hospital system's capacity to respond to a bioterrorist event through collaboration and coordination with our key partners: hospitals, local health jurisdictions, emergency management services, EMS, and health care providers. The plan emphasizes the need to work closely with Centers for Disease Control (CDC) activities to develop capacity and systems for public health preparedness and planning. An effective hospital response system requires the following critical elements: regional hospital readiness and preparedness plans, protocols, and procedures for managing mass casualties; improved communications between hospitals and local health jurisdictions; personal protective equipment for health care providers; plans for stockpiling and distributing mass vaccinations and antibiotics; and an educational delivery method which ensures responder competence to recognize and treat acts of bioterrorism or other outbreaks of infectious disease.

The Work Plan
The work plan identifies a process for addressing hospital needs, regional hospital plan development and implementation, and methods to ensure coordination with local health jurisdictions, emergency management and the CDC activities. The work plan is organized in two phases with a number of HRSA-required elements and critical benchmarks found within each phase:

Phase 1
Application for Phase 1 funding of approximately $506, 000 was submitted February 15, 2002 to HRSA. At HRSA's direction, Phase 1 funding will pay for a needs assessment and a plan to address the needs identified. Funding for this initial award will be used to cover required critical benchmarks detailed below. This funding will also go toward proposed expenditures to purchase hospital personal protective equipment, upgrades and improvement to the statewide Washington Emergency Radio System and the Puget Sound Hospital Capacity Website. Linkages with the Spokane area hospital capacity Website will also be pursued.

Phase 2
The remaining 80 percent, or $2,026,734, will go to support the following grant requirements:

- **Needs Assessment** - DOH and the Washington State Hospital Association will work with the newly established Hospital Bioterrorism Preparedness and Planning Committee to evaluate existing needs assessments and determine gaps and deficiencies regarding hospital capacity to respond to public health emergencies. Where information is lacking, a needs assessment tool will be developed. Results of the needs assessment will be used to develop a model or template for regional hospital response plans. The results will also be used in determining hospital needs to improve response capacity. This process will include collaboration with the DOH led CDC activities, as well as coordination with Emergency Management's Committee on Terrorism and the three Metropolitan Medical Response System cities (Seattle, Tacoma, Spokane). These collaborative efforts will ensure efficient use of resources while minimizing duplication of effort.

- **Critical Benchmarks** – As directed, DOH has addressed plans for meeting HRSA's three critical benchmarks:
  1. Program Direction – DOH will hire a Coordinator for Bioterrorism Hospital Preparedness Planning, Health Services Consultant and Medical Director to ensure DOH leadership and coordination of the CDC, HRSA, and Metropolitan Medical Response System.
  2. Hospital Bioterrorism Preparedness Planning Committee – A Hospital Bioterrorism Committee has been established and follows HRSA's direction to include membership of the following entities:
     - State Health Department
     - State EMS Office
     - State Emergency Management
     - State Hospital Association
     - State Office of Rural Health
     - Veteran Affairs and Military Hospital
     - Primary Care Association

     DOH has also included representatives from:
     - Local Public Health, the Governor's Office of Indian Affairs, Fire Chief's Association, Firefighters Council

  3. Regional Hospital Plans – DOH has proposed a process for developing regional hospital plans to manage 500 or more patients. Following review of best practices and existing regional models for hospital preparedness and response, a regional

hospital response template will be developed. This template will be provided to all of Washington's hospitals as guidance for the development and implementation of regional hospital response plans. To ensure regional hospital plan development and implementation, DOH will contract with Regional EMS and Trauma Care Councils to coordinate regional planning activities. This will also ensure linkage with the local health officer, regional health jurisdiction coordinator and local emergency management. The EMS regional councils will coordinate their hospital preparedness planning with the CDC activities through collaboration with the local health jurisdictions and the regional health jurisdictions. DOH and the Hospital Bioterrorism Preparedness and Planning Committee will monitor HRSA and CDC related activities.

First Priority Planning Areas – Among the activities HRSA has asked Washington to address in the First Priority Planning Areas are: plans to make antibiotics and vaccines available statewide, upgrade existing decontamination systems, improve communication capacities, and testing biological response plans. Working with the DOH-led CDC work group, the HRSA First Priority Planning areas will be concurrently addressed. Much of the work will center on conducting needs assessments, addressing those needs, and development and implementation of plans based on the needs identified. This will avoid duplication of effort and ensure plan integration.

Second Priority Planning Areas – Second Priority Planning areas will be addressed following successful completion of the First Priorities Areas. HRSA has asked Washington to address such issues as the plans for hospital recruitment, training delivery, and use of backup facilities. The Second Priority Planning Areas will follow the same collaborative process outlined in the First.

Infrastructure – HRSA has also requested plans for how DOH intends to demonstrate medical direction, local and regional preparedness with other disaster plans, system development costs, sustainability of the plans, and addressing laws that may impact timely response to bioterrorism.

- Medical Direction – DOH proposes to hire a part-time medical director to provide advice on medical protocols and procedures. DOH will also seek guidance from the Washington State Medical Association, county physician medical program directors, and local health officers.
- Local & Regional Preparedness with other Disaster Plans – DOH proposes building upon existing response plans with development of specific protocols and procedures for biological events. Regional hospital preparedness plans must be coordinated with and signed-off by the local health officer and local emergency management.
- System Development Costs – DOH proposes the distribution of funds to all 95 licensed hospital facilities in Washington for conducting needs assessments, and regional hospital plan development. Funding will also be provided to the Regional EMS and Trauma Councils to ensure coordinated regional planning and linkage with the regional health jurisdictions, local health officers and local emergency management. In accordance with HRSA guidance, not more than 20 percent of the $2,026,734 will go to support DOH staffing and statewide oversight of needs assessments and planning efforts.
- Sustainability of Preparedness Plans – DOH expects that hospitals, local health jurisdictions, and Regional EMS Councils will find that plan updates and conducting

drills will be integrated into enhanced public health capacities. Disaster readiness and preparedness activities will become critical public health activities.

- Legislation and Regulation – DOH will work closely with the state Board of Health, local health jurisdictions, and the attorney general's office as well as other partners to address legal issues and barriers.

Data Collection – The requirement to collect hospital data throughout the regions and provide reports to DOH will be built into the proposed funding provided to the Regional EMS and Trauma Care Councils. These reports will be used to provide semiannual reports to HRSA.

Summary: DOH's proposed hospital bioterrorism grant application describes a collaborative process among hospitals, local health jurisdictions, emergency management, EMS, and key partners and stakeholders, as well as other health care entities. DOH will ensure this includes the activities of the CDC program, HRSA, and MMRS. This will create an integrated and comprehensive statewide public health response system to respond to a biological terrorist event or other large-scale public health emergency.

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A. Background and History

Washington State's recent experience with a potential bioterrorism incident involved SeaTac International Airport, a scheduled flight from Taiwan, and a potential smallpox carrier aboard that flight.

On December 5, 2001, local authorities and the Public Health--Seattle & King County (PHSKC) were notified that a passenger on a plane in-bound from Taiwan "carrying" smallpox. The Incident Commander at SeaTac consulted PHSKC for recommendations on handling the incident. While initial information available through the FBI indicated that the incident was most likely a hoax, all responding agencies agreed to proceed with due caution. The Washington State Department of Health (DOH) provided additional consultation and advice. Reports from the plane's crew indicated the passenger appeared fatigued but there was no visible indication of a rash.

The plane was boarded and Emergency Medical Services (EMS) providers confirmed the crew's evaluation of the patient's physical appearance. The patient was fatigued and had a low-grade fever. Concerned about the fever, PHSKC considered several options for monitoring the patient for the next 24-36 hours. Two local hospitals were contacted about admitting the patient for observation. Both declined the initial request on the basis that they were not immediately prepared to accept a patient who may develop smallpox. One of the hospitals, however, eventually agreed to evaluate the case. Other options to house the patient were pursued.

Later, a PHSKC physician examined the patient at SeaTac and determined that the patient was not clinically ill with smallpox. As a result, the FBI, Immigration, and Customs found no reason to detain the patient. The patient was released with instructions to immediately call PHSKC if his fever increased or he developed a rash. CDC also monitored the patient's movements through the remainder of his stay in the U.S.

Following the incident, Dr. Jeff Duchin, Chief, Epidemiology, Communicable Disease and Immunization Section of PHSKC convened a meeting with hospital

administrators, medical chiefs of staff, and infection control physicians. This Outbreak Response Work Group agreed on the need for a regional plan for the hospitalization and treatment of smallpox patients. Using the CDC guidance on response to a smallpox outbreak, hospitals were surveyed to determine the number of facilities and capacity to isolate smallpox patients. After further consultation with CDC, eight King County hospitals agreed to accept a limited number of suspected smallpox patients. The identification of a cohort hospital for the mass treatment of patients is ongoing. In addition, one of the hospitals contacted during the incident at SeaTac has scheduled a drill for April 2002 to evaluate their new policies and procedures for receiving smallpox patients. PHSKC[1] is assisting in the planning of the drill and will have observers at that hospital.

Lessons learned from this incident are: (1) hospital facilities even in the most urban area of the state are not prepared to handle bioterrorism casualties, particularly smallpox patient(s), (2) local health jurisdictions[2] (LHJs) need a plan in place to address these and similar contagion issues, and (3) there is a need to address these issues in detail by LHJs, DOH, and the entire prehospital and hospital system across Washington State.

Regarding current efforts aimed at emergency planning in the State, and a description of the role of the organizations currently involved, please see the five sections below, particularly "Description of current antiterrorism and disaster planning initiatives within the State."

Existing Federal, State and local resources in the State, including hospitals, outpatient facilities and EMS systems, with identified gaps in capacity:

All current resources in the state, including the hospital and prehospital system, are being coordinated to develop, implement, and support the current statewide emergency planning efforts. The Washington Emergency Management Council's Committee on Terrorism (COT) has the lead the effort to develop and implement the statewide plan to prepare for and mitigate the effects of bioterrorism or other similar disasters. The federal, state, and local organizations involved in the COT (listed below) are all active participants in this statewide emergency planning effort, including both public and private organizations. Gaps in local and regional emergency response capacity, at both the prehospital and trauma facility levels,

[1] CDC – HRSA Coordination
[2] CDC – HRSA Coordination

have been identified as part of the regional planning process in the eight regional EMS and trauma care plans currently in place in Washington state. Gaps in the preparedness and response capability of hospitals will be identified and targeted for amelioration by the newly appointed Washington Hospital Bioterrorism Preparedness Planning Committee (HBPPC), as part of the Washington Emergency Preparedness plan for FY 03.

Existing collaboration between hospitals, outpatient facilities and EMS on both terrorism and general disaster response initiatives:

Collaboration between hospitals and the Washington EMS/trauma care system on general disaster response initiatives has been in place in Washington State for over ten years. Statutory requirements mandate hospitals and prehospital agencies to work cooperatively in designing and implementing local and regional EMS and trauma care plans and systems, through the vehicle of their DOH-approved regional EMS and trauma care plan. These requirements also include direction to regional councils to plan for addressing inter-regional patient care responses, and the EMS and trauma system response to mass casualty incidents at all levels. DOH has established eight regional E.M.S. and trauma care councils. These regional councils perform the following activities: (1) assess and analyze regional EMS and trauma care needs; (2) identify and implement specific activities necessary to meet state-wide standards and patient care outcomes; (3) establish the number and levels of facilities to be designated as trauma facilities; (4) identify the need for and recommend the distribution and level of care of prehospital services, to assure adequate availability and avoid duplication of services; and (5) advise DOH on all matters relating to EMS and trauma care delivery within the region.

Regional council members, nominated by local EMS and trauma care councils and appointed by the DOH, are comprised of a balance of:

- Hospital providers
- Emergency medical services providers
- Local elected officials
- Consumers
- Local law enforcement representatives
- Local government agencies

Some regional councils currently include local emergency management, LHJs, tribal, and fire service representation. To ensure all EMS/TC[3] regional councils have included these entities as a part of their membership, DOH will direct regional councils to submit names of representatives of these organizations to DOH for appointment. EMS and trauma care regions were originally established based on patient flow patterns in Washington State. They are currently the focal point for EMS and trauma care service planning, implementation, and service provision statewide. Regional hospital planning will build on this existing infrastructure through EMS/TC regional councils serving as the coordinating body for regional hospital plans.

System direction regarding patient care at the scene, prehospital determination of patient facility destination, and facility requirements regarding the treatment of both emergent and trauma patients are also areas of joint development between hospitals and prehospital agencies. The tools presently in existence are the Washington State Trauma Triage Tool (TTT), regional Patient Care Procedures (PCPs), regional patient care protocols, and County Operating Procedures (COPs). Training for responses to mass casualty incidents is provided under contract from DOH for both hospital and prehospital personnel. Local emergency management personnel are included in the planning for both the local and regional EMS/TC systems, which determines the most appropriate methods of cooperation for all aspects of the patient care response system in Washington State. In addition, local Mass Casualty Incident (MCI) planning conducted through local emergency management agencies regularly includes local EMS council (e.g., hospital and prehospital) participation.

Current collaboration with other local, State, and regional health agencies related to public health, rural health, public safety and emergency management. An organizational chart that describes the relationship of the health department to other State agencies involved in bioterrorism response:

Please see section directly below about collaboration between DOH* and other local, state and regional healthcare and health services agencies regarding emergency preparedness planning. The organizational chart for the Governor's Domestic Security Infrastructure, showing the relationship of the Washington State Emergency Management Committee, the Committee on Terrorism, and other

[3] CDC – HRSA Coordination

state, local, and federal agencies involved in the current planning and program implementation for bioterrorism response is attached as Appendix 1.

Description of current antiterrorism and disaster planning initiatives within the State, that addresses hospital, outpatient and EMS participation, available resources, and amount and sources of funding already available:

Emergency planning efforts currently underway in Washington State to address bioterrorism and associated disaster issues are focused through the efforts of the Washington State Emergency Management Council (EMC), and more specifically through it's Committee on Terrorism (COT). The Governor has charged EMC and COT with: (1) developing a statewide strategy for preventing, planning, and responding to threats and acts of terrorism, and; (2) providing a forum for general coordination and the exchange of information among federal, state, and local entities.

COT[4] is co-chaired by an Assistant Secretary of the DOH and the Whitman County Sheriff, and consists of organizational representatives from DOH, including the Office of EMS and Trauma Systems; Washington Military Affairs Department, Emergency Management Division; Washington Department of Information Services (DIS); Washington State Patrol (WSP), including the WSP Fire Protection Bureau; Washington Department of Transportation (DOT); Washington Department of Ecology (DOE); Washington Department of Labor and Industries (L&I); Washington Attorney General's Office (AGO); Washington Department of Social and Health Services (DSHS); Washington Office of Financial Management (OFM); Washington Association of Fire Chiefs; Washington Association of Police Chiefs; Washington National Guard; the Washington State Hospital Association; local public works agencies; LHJs; local emergency management agencies; local fire departments, and local and regional EMS and trauma systems.

In addition, active advisory members to COT include representatives from FEMA, the U.S. Coast Guard, the EPA, the Department of Defense, the FBI, the U.S. Public Health Service, the Washington Department of Personnel (DOP); Washington Employment Security Department (DES); and the Washington Criminal Justice Training Commission.

[4] CDC – HRSA Coordination

COT has established a Grants and Resources Subcommittee, which is tasked with determining the total resource availability at the local and state levels for emergency and disaster planning within the state, including the availability and sources of training and equipment funds. To date, the resources available and specifically earmarked for emergency and disaster responder training and equipment for Washington State have been a $907,000 grant from the U.S. Department of Justice for FY 99, and continuation grants from the same program, now under FEMA, for $1,455,000 in FY '00, and $900,000 for FY '01.

Current status of hospital, outpatient and EMS systems with respect to patient flow, bed capacity, overcrowding, diversion, and surge capacity:

The Washington Emergency Medical Services and Trauma Care (EMS/TC) system regional service provision network Washington originally developed and implemented geographically based on regionalized patient flow patterns, i.e., the flow of patients from rural areas to small town facilities, and then depending on the type and severity of injury, to larger regional facilities, and/or to large specialized care facilities. These patient flow patterns were institutionalized on a statewide basis in 1990 in the development and operation of the statewide trauma system. This system required regional EMS and trauma care councils to develop a blueprint and guidelines for system operation. These guidelines or PCPs help prehospital personnel to determine, within the parameters of the TTT, the destination facility for trauma and emergent patients. At present, regional hospital plans are not adequate to manage 500 patients or more. PCPs also create the framework for deciding when an overcrowded facility goes on diversion. At such time, the EMS system would respond by taking new patients to the closest specified facility available. Surge capacity is dependent on the determination made by each facility regarding maximum capacity.

B. Needs Assessment

A plan for assessing the unmet needs the State has in order to be able to implement a hospital and EMS bioterrorism response - a summary of the results to date and a time line for addressing further issues, including measurable milestones to facilitate accountability:

Need for a bioterrorism plan that addresses triage, isolation, quarantine, decontamination, stabilization, treatment and referral of multiple casualties (whether presenting all at once or gradually over time):

DOH and the Washington State Hospital Association (WSHA) with assistance from the HBPPC and other community health agencies (e.g., Washington Association of

Community and Migrant Health Centers (WACMHC)) will first review existing surveys relating to facility capacity to manage triage, isolation, quarantine, decontamination, stabilization, treatment and the referral of multiple casualties. Where insufficient information exists or there is a lack of clarity, DOH, WSHA, WACMHC, and HBPPC will work collaboratively to develop an assessment tool to address these issues. This joint development will determine the scope and content of the assessment tool and DOH will coordinate with the CDC Public Health Preparedness for Bioterrorism Response cooperative agreement (CDC Initiative) staff to identify and resolve redundancies. HBPPC will review and provide recommendations to DOH regarding the content and the plan for implementation of the assessment tool. The assessment will be conducted, and results compiled and reviewed. These results will be presented to HBPPC for discussion and integration into model regional hospital plans. The Committee will recommend prioritization of the needs and address funding implications and potential funding distribution methods required. Work plan timelines are attached as Appendix 2.

Need for reconfiguration of hospital space for quarantine of communicable diseases and treatment of infectious disease epidemics, including provision of security services:

Needs related to hospital space reconfiguration and security concerns will also be identified via the needs assessment instrument and the ensuing review process, as stated above. Work plans are attached as Appendix 2.

Need for personnel augmentation (physicians, nurses, pharmacists, mental health professionals and others) to handle large influxes of patients:
Please see section below.

Need for licensing, credentialing and supervision of clinicians not normally working in facilities responding to a bioterrorist incident:

In Washington, the Emergency Management Act provides:

> "Any requirement for a license to practice any professional, mechanical or other skill shall not apply to any authorized emergency worker who shall, in the course of performing his duties as such, practice such professional, mechanical or other skill during an emergency described in this chapter."

DOH is currently determining how healthcare practitioners from other local health jurisdictions will be processed and is exploring the feasibility of issuing healthcare practitioner identification cards. There has been discussion of some minimal credentialing procedures, i.e. checking with the other jurisdictions to make sure

the person is a licensee in good standing, and this is still under review by DOH. The question of emergency credentialing also impacts the private privileging system of hospitals. Currently, there is no procedure in place that provides for the overriding of those privileging systems due to a public health emergency. This situation may create issues with the Joint Commission on Accreditation of Healthcare Organizations (JACHO) around standards, and DOH is in the process of determining whether or not JACHO standards would need to be modified to override the privileging system.

The legal question of supervision in an emergency situation is also unclear, and currently under review by DOH. There has been some discussion concerning modification of scope of practice in public health emergencies, but this has raised a number of concerns and, generally, there was a consensus at the state that such modification was unnecessary. It is generally believed there would be sufficient numbers of volunteers in the necessary disciplines. It would not be necessary to modify scopes of practice so a nurse could perform surgeries unsupervised, or veterinarians could practice on humans, for example. These assumptions will be tested via the needs assessment.

The development of a plan addressing these questions will require negotiation with hospitals and other facilities, and perhaps some modification of privileging requirements in DOH Facilities and Licensing (FSL) statutes, regulations, and possibly JACHO requirements. DOH will develop a plan to negotiate with hospitals and work to modify the necessary requirements to clarify and institutionalize these issues during FY '03.

Need for mechanisms to manage unsolicited clinical help and donated items:

DOH[5] is currently reviewing the potential options regarding clarification of the "unsolicited volunteer" issue, specifically reviewing the potential implementation of mutual aid agreements among local public health jurisdictions, as well as state and local coordination with federal resources specifically regarding the availability of Medical Reserve Corps volunteers. See section above for additional details.

Need for protection of clinicians (vaccination, antibiotic prophylaxis, personal protective equipment, education) to ensure their availability in an epidemic:

[5] CDC – HRSA Coordination, see Focus Area G

The need for the protection of clinicians will be identified through the needs assessment instrument and the ensuing review process as stated above.

Need for training in recognition of rare diseases with bioterrorism potential:

The need for training in recognition of rare diseases with bioterrorism potential will be identified via the needs assessment instrument and the ensuing review process as stated above.*

Need for diagnostic and treatment protocols addressing bioterrorist infectious diseases with early nonspecific syndromes, and for mechanisms to bring clinicians up to speed on these protocols before and during a bioterrorism event:

The needs assessment process as described above will also target diagnostic and treatment protocol needs.

Need for pharmaceuticals and vaccines for patients or exposed individuals:

There are three designated Metropolitan Medical Response System (MMRS) cities in Washington, Seattle, Tacoma, and Spokane. Seattle is the only MMRS city that has fully operational MMRS capability, with Tacoma and Spokane still developing and implementing their programs. These cities account for approximately half of the state population. Each MMRS city currently has a quantity of pharmaceutical stock on hand but needs to report the quantities and other information concerning local stockpiles to DOH. The Washington National Pharmaceutical Stockpile (NPS)[6] plan is currently in final draft form and has been partially tested, specifically regarding distribution capabilities, through a dispensing drill held in Seattle, on January 24, 2002. DOH anticipates that the completed state NPS plan will be in effect by July 2002. In summary, the Washington NPS plan specifies that the state will request NPS assets from CDC when it is apparent that state stocks will soon be exhausted or when the nature of the emergency has the potential of overwhelming the state system, including the resources available locally.

Needs of children, pregnant women, the elderly and those with disabilities:

The needs assessment process as described above will target the needs of children, pregnant women, the elderly and those with disabilities.

[6] CDC – HRSA Coordination, see Focus Area A (NPS)

Need for infrastructure and collaboration between hospitals and EMS systems that support effective diversion and referral plans:

Infrastructure for and collaboration between the hospital and EMS systems is currently in place and exists through the patient care structure created following the passage of the 1990 Washington trauma legislation. However, there is a need to improve coordination and communication capacities between hospitals, local health jurisdictions and the state health department.[7] This patient care structure consists of the TTT, which provides direction to prehospital personnel statewide regarding triage and destination determination procedures for major trauma patients. As previously stated, DOH-approved PCPs, developed by hospitals and pre-hospital agencies through their participation in regional EMS and trauma care councils, are a blueprint for system operation regarding both emergent and trauma patients and include operational instructions for patient diversion and referral. DOH-approved COPS are developed and implemented by hospitals and prehospital agencies at the county level, under the umbrella of the regional PCPs and state TTT, to add required specificity to those general EMS/TC system guidelines established by the state TTT and the PCPs. Because comprehensive bioterrorism regional hospital plans do not currently exist to deal with large numbers of casualties, system coordination is essential. In order to ensure coordination with local health jurisdictions and local emergency management, all regional hospital plans must have the approval of local health officers and local emergency management. It is expected that the regional EMS and Trauma Care Councils in collaboration with the regional health jurisdiction coordinators identified in the CDC* Bioterrorism Plan Proposal will ensure integration of planning efforts. Hospital membership is also required on regional EMS/TC councils to ensure ongoing coordination and collaboration.

Need for identification of emergency departments and outpatient centers capable of initial assessment and treatment of biological exposures:

A survey will be conducted in conjunction with WSHA[8] to identify both the existing and required levels of education and training needed for personnel in hospital emergency departments and outpatient centers to assess and treat biological exposures, including a determination of the need for equipment and/or other capital expenditure in this area. Based on the survey results and concurrent

[7] CDC – HRSA Coordination, see Focus Area A
[8] CDC – HRSA Coordination, see Focus Area G

"best practices" reviews, education and training levels for facility personnel will be established. Equipment standards will be also be established and implemented for equipment required for assessment and treatment of biological exposure in patients. The final regional hospital bioterrorism plans will address these issues by each facility.

Need for linkages to sources of expert consultation and referral centers capable of addressing biological exposures definitively (such as a communicable diseases isolation facility that can serve as the dedicated referral hospital for CDC's Division of Global Migration and Quarantine):

Current linkages to expert consultation regarding communicable diseases within Washington State are focused on the DOH Office of Communicable Disease Epidemiology and the State Public Health Laboratory (WAPHL)[9], with further linkage from there to CDC. Under the CDC Initiative, additional experts will be identified around the state and regional capacity is being developed to provide technical assistance to clinicians, facilities and local health officials who may be addressing biological exposures. Most hospital facilities in the state do not have the capability, or have little capability, for isolating patients diagnosed with or being tested for communicable diseases. This capacity will be developed regionally and put into place as specified in the hospital bioterrorism preparedness timeline.

Need for delivery to facilities and individual casualties of essential goods and services such as food, water, shelter and electricity:

Working collaboratively with LHJs and emergency management, hospital facilities[10] will be required to submit regional plans regarding continued and uninterrupted deliver of essential goods and services to the facility in the event of a communicable disease incident in their patient catchment area, including food, water, and medical supplies. Hospitals will also be required to have a plan for providing shelter for patients in the event of patient overload, and to specify the backup power supply for the facility.

Any existing gaps in objective data that inhibit planning:

[9] CDC – HRSA Coordination, see Focus Area C
[10] CDC – HRSA Coordination, see Focus Area A

Existing gaps in objective data, described above, will be filled by defining required data reporting categories relating to bioterrorism preparedness by hospitals, and including those categories within the current hospital data reporting system.

Need for technical assistance from the HRSA Bioterrorism Hospital Preparedness Program or its contractors:

Technical assistance needs revealed through the planning process will be addressed and formal requests to HRSA will be developed as appropriate over the two-year grant period.

C. Critical Benchmarks

The implementation plan includes the three specific critical benchmarks included in the letter from Secretary Thompson to the Governors.

1. Program Direction: There must be leadership at the health department level to ensure coordination of all three funding streams. In addition, specific direction for the hospital preparedness plan will be needed.

Designate a Coordinator for Bioterrorism Hospital Preparedness Planning. Describe the duties of the coordinator.

Bioterrorism Hospital Preparedness Coordinator- (1) FTE:
There has been a delay in the final designation of the Bioterrorism Hospital Preparedness Coordinator. However, the selection process is active. DOH will hire a coordinator. This position will coordinate activities necessary to improve the capacity of Washington's hospitals and healthcare system to respond to bioterrorist attacks as well as to other public health emergencies. One (1) FTE is needed to coordinate:

- Upgrades to the preparedness of hospitals and healthcare systems to respond to bioterrorist events or non-terrorist epidemics and outbreaks of rare diseases;
- Identification and implementation of bioterrorism preparedness plans and protocols for hospitals and other participating healthcare entities;
- Development of statewide models for protocols; and
- Collaboration with other states, Canada, and national organizations.

Description of duties:

At the direction of the DOH Senior Public Health Official,[11] this position will work to assure:

- Completion and implementation of a needs assessment for a comprehensive hospital bioterrorism preparedness program including development of Phase 2 proposals;
- Coordination and collaboration of the Phase 1 needs assessment and implementation plan with plans being developed from CDC and OEP funds;*
- Completion of a plan that addresses the priorities identified in the needs assessment and takes into consideration the need to build upon and maximize existing resources at local, regional and state levels;
- Development of hospital partnerships and improved communications between local health jurisdictions, local emergency management, and local EMS systems;*
- Integration of planning and implementation efforts between the DOH Bioterrorism Preparedness and Response Program, the Statewide Bioterrorism Advisory Committee, Hospital Bioterrorism Preparedness Planning Committee, Emergency Management Council's Committee on Terrorism, the EMS & Trauma Care Steering Committee's Hospital Technical Advisory Committee and any other collaborating entities that improve hospital preparedness;*
- Staff support related to the activities of the Hospital Bioterrorism Preparedness Planning Committee; and
- Integration of the appropriate Critical Benchmarks for Bioterrorism Preparedness Planning criteria in plan development and implementation.

Include a curriculum vita that describes the education, training and experience that qualify this person for the task.

The hiring process to fill the position of Hospital Bioterrorism Preparedness Coordinator is currently underway. The person hired will have qualifications that will enable them to fulfill the duties described above. DOH will submit to HRSA a curriculum vita upon final designation of the coordinator.

2. Hospital Bioterrorism Preparedness Planning Committee: This committee will have been established during phase 1. It should meet at least once during the planning phase, and quarterly during the implementation phase, to provide guidance,

[11] CDC – HRSA Coordination, see Focus Area A

direction and oversight to the state health department in planning for bioterrorism response.

A description or charter defining the mission and duties of this planning committee:

Background: The Hospital Bioterrorism Preparedness Planning Committee consists of partners and representatives of stakeholder groups that will assist DOH in upgrading the preparedness of Washington's hospitals to respond to bioterrorism. HRSA is funding this initiative for the development and implementation of regional plans to improve the capacity of hospitals, their emergency departments, outpatient centers, EMS systems and other collaborating healthcare entities for responding to incidents requiring mass immunizations, treatment, isolation and quarantine in the aftermath of bioterrorism or other outbreaks of infectious disease.

Proposed Membership: The Hospital Bioterrorism Preparedness Planning Committee will be comprised of the following members:

- Washington State Department of Health
    - Office of Emergency Medical and Trauma Prevention
    - State Office of Rural Health
- Washington State Hospital Association
- Washington Association of Community and Migrant Health Centers
- Washington State Medical Association
- Washington State Nurses Association
- Washington State Military Department, Emergency Management Division
- Washington State Department of Veterans Affairs
- United States Army, Madigan Army Medical Center
- Washington State Association of Local Public Health Officials
- Washington State Emergency Management Association
- Washington State Department of Labor and Industries
- Washington State Fire Chiefs Association
- United States Department of Health and Human Services, Region 10 Office of Emergency Preparedness
- Association of Washington Public Hospital Districts
- Washington State Governor's Office of Indian Affairs
- Harborview Medical Center

- Washington State Council of Firefighters
- Washington State Dental Association

Mission and Duties: The Hospital Bioterrorism Preparedness Planning Committee has an advisory relationship with the DOH.[12] The Committee will work collaboratively with the Statewide Bioterrorism Response Advisory Committee (BRAC) to:

1. Upgrade the preparedness of Washington's hospitals and healthcare system to respond to bioterrorist events;
2. Prepare the healthcare system to deal with non-terrorist epidemics and outbreaks of rare diseases;
3. Identify and implement bioterrorism preparedness plans and protocols for hospitals and other participating healthcare entities;
4. Serve as an information conduit to communicate and educate partners and stakeholders on hospital plan development, expectations, and needs;
5. Develop statewide models of protocols;
6. Collaborate with other states and Canada;
7. Improve the mission of the state's plan to address ESF #8; and
8. Evaluate progress toward plan implementation.

Meeting Process: The Hospital Bioterrorism Committee will meet quarterly during the implementation phase and will hold one meeting during the planning phase. Meetings will be held in Olympia or the Puget Sound area. The Department of Health will provide meeting staffing support. The majority of the Hospital Bioterrorism Committee work will be conducted via e-mail.

A current roster of the planning committee, and the rationale for inclusion of each member:

The Hospital Bioterrorism Preparedness Planning Committee assists DOH and the Statewide Bioterrorism Advisory Committee in hospital preparedness efforts. Per the section above, the anticipated composition of the group and a brief rationale for inclusion of each member are:

- **State, Territorial or Municipal Health Department**- One state DOH representative to assure the integration of planning and implementation efforts between CDC, OEP funds, completion of critical benchmarks, and to provide the

[12] CDC – HRSA Coordination, see Focus Area A

committee with input regarding the activities and decisions of DOH and other state committees engaged in bioterrorism preparedness activities (e.g., Emergency Management Council's, Committee on Terrorism). The state DOH representative will seek to assure improved communications and partnerships between hospitals, local health jurisdictions, local emergency management, and local EMS systems.

Representative and Chair –Mary Selecky, Department of Health Secretary

- **State Hospital Association (WSHA)**-One Washington State Hospital Association representative to provide input on hospital needs and plans for addressing identified needs in order to bring every hospital in the state to a reasonable level of readiness. Focus areas in need of improvement, but not limited to the following areas include: community-wide preparedness, staffing, staff training and mobilization, communications (to include victim identification, monitoring bed capacity via the internet), hospital and healthcare provider licensure and credentialing, facility backup, and upgrading hospital infrastructure in such areas as infection control and mass casualty management

  Representative – Peggi Shapiro, WSHA Disaster Readiness Director

- **Primary Care Associations-**
  Representative –Gloria Rodriguez, Chief Executive Officer, Washington Association of Community and Migrant Health Centers

Other entities-

- **Washington State Medical Association (WSMA)**: One representative from the WSMA to assure WSMA identified needs are integrated with the plan of action. Focus areas of improvement include but not limited to the following: staffing, credentialing privileges, physician education on biological illness, and mobilizing physicians during a public health emergency, and assure local medical community response is linked to local emergency management and local health jurisdiction efforts. WSMA's guidance will help assure planning and implementation decisions are based on sound medical practice while helping to assure improved hospital and healthcare system readiness to respond to a biological event.
  Representative – Nancy Auer, MD, WMSA Past President

- **Washington State Nurses Association (WSNA):** One representative from WSNA to assure WSNA needs are integrated with the plan of action. Focus areas of improvement include but not limited to the following: staffing,

nurse education on recognizing and responding to potential bioterrorism disease agents, personal protective equipment, mobilizing nurses during a public health emergency, and public communications.
Representative – Joan Garner, WSNA Director of Nursing Practice, Education, Government/Public Relations and Member Services

- **State Emergency Medical Services Office**- One representative from the state Office of Emergency Medical and Trauma Prevention to provide input on local, regional and statewide EMS system needs and to assure integration of planning and implementation efforts between the state Emergency Medical Services and Trauma Care Steering Committee and the Hospital Bioterrorism Preparedness Planning Committee, and the 8 regional EMS & Trauma Care Councils.
  Representative – Janet Griffith, Director, Office of Emergency Medical and Trauma Prevention

- **State Emergency Management Agency-** One representative from the Washington Military Department's Emergency Management Division to assure integration of committee planning and implementation efforts with the state Comprehensive Emergency Management Plan, (Essential Services Function #8), and to assure efficient use of state and federal resources associated with the activities of the Hospital Bioterrorism Preparedness Planning Committee and the state Emergency Management Council's Committee on Terrorism.
  Representative – Jeff Parsons, Emergency Management Division Analysis and Plans Manager

- **State Office of Rural Health-** One representative from the state office of Rural Health to assure rural and urban underserved healthcare provider needs are addressed. Focus will be on obtaining input from those providers on their unique concerns, needs and capacity relative to bioterrorism planning: assisting in devising and implementing relevant communication to those providers (e.g. rural health clinics, federally funded health centers, critical access hospitals, Indian Health Service Centers, etc.)
  Representative – Alice James, Office of Rural Health, Rural Health Systems Manager

- **Military Hospitals-** One representative from Madigan Army Medical Center to assure healthcare system understanding of the military's roles, responsibilities, and available resources during a biological terrorist event.
  Representative – Colonel Daniel Davidson, MD, Madigan Army Medical Center, United State Army
- **Veteran Affairs-** One representative from Veteran Affairs to assure healthcare system understanding of the V.A. facilities backup role and available resources during a biological terrorist event.
  Representative – Ed James, Veterans Affairs Area Emergency Manager, VISN-20 (OR, ID, WA, AK)

- **Washington State Association of Local Public Health Officials (WSALPHO):** One representative from WSALPHO to assure local health needs are integrated with the plan of action. Focus areas of improvement include but are not limited to: improved community linkages between hospitals, local health jurisdictions, local emergency management and local EMS, rapid identification and response, policy and evaluation, improved funding to meet core capacities, maintaining adequate workforce during routine and emergency response, and establishment of surge capacity for LHJs.
  Representative – Kim Thorburn, MD, MPH, Spokane Regional Health District Health Officer

- **Washington State Local Emergency Management:** One representative to assure local emergency management needs are integrated with the plan of action. Focused areas of improvement include: current preparedness and response plans identifying roles and responsibilities between hospital, local health jurisdiction, and emergency responders, assure understanding and the practice of the incident command system, establishment of local mutual aid agreements or compacts to maximize and share resources across local and regional boundaries, and the ongoing exercise of emergency response plans.
  Representative – Phyllis Mann, Past President, Washington State Emergency Management Association

- **Washington State Department of Labor & Industries (L&I):** One representative to assure compliance with L&I standards for personal protective equipment (PPE) and interoperability. Focus areas of improvement include but are not limited to: workforce safety while rendering care to a victim of biological disease agent, and training on appropriate use of PPE's.

Representative – John Furman, Department of Labor and Industries, Occupational Nurse Consultant, WISHA Policy and Technical Services

- **Washington State Fire Chiefs Association:** One representative to assure committee member understanding of Washington's all hazards statewide Fire Mobilization plan. WSFCA input and technical assistance to the committee will serve to inform committee members on an existing statewide response model for mobilizing resources.

Official Member Pending

- **Office of Emergency Preparedness:** A representative from Region X Office of Emergency Preparedness to provide guidance and technical assistance to assure the integration of Washington's MMRS designated cities (Seattle, Spokane, and Tacoma) in needs assessment and planning efforts.
  Representative – Captain Andrew Stevermeer, DHHS Region 10 Emergency Preparedness Coordinator

- **Association of Washington Public Hospital Districts:** A representative from the Association of Washington Public Hospital Districts to assure rural hospital readiness and preparedness needs are adequately addressed. Focus areas in need of improvement, but not limited to the following areas include: coordinate with state and local agencies/jurisdictions staffing, staff training and mobilization, personal protective equipment, communications, increasing preparedness levels with limited resources, and role of critical access hospitals.
  Representative – Taya Briley, AWPHD, Legal Services and Health Policy Director

- **Office of Indian Affairs:** One representative to assure tribal healthcare issues are adequately addressed. Focus areas in need of improvement, but not limited to the following areas include: communications, sharing resources, building linkages with hospitals, local health jurisdictions, local emergency management, and local EMS.
  Representative – Kimberly Craven, Executive Director, Governor's Office of Indian Affairs

Additional members of the HBCC are :

Harborview Medical Center: The state's largest trauma facility.
Duane Mariotti, Clinical Engineering Director

Washington State Council of Firefighters
Lieutenant Ted Rail, City of Spokane Fire Department.

Washington State Dental Association
Frank Morgan, DDS, Chair, Mass Disaster Identification Team

The planning committee will be required to sign off on State or regional hospital preparedness plans submitted to HRSA.

The Committee, chaired by Secretary of Health Mary Selecky,[13] met on March 25, 2002, to review the draft state Bioterrorism Hospital Preparedness Program and to provide comments and recommendations on the content of the draft plan to DOH. At that meeting, the Committee unanimously approved a motion supporting the DOH application and the content of the Bioterrorism Hospital Preparedness Program plan. The Hospital Bioterrorism Planning Preparedness Committee will continue to function in its advisory capacity to DOH, and to review and address hospital preparedness plans as they are developed, providing recommendations to DOH regarding content and compliance of those plans.

3. Regional Hospital Plans: A timeline that describes the approach to development and implementation of a regional hospital plan for large-scale epidemics, to include the following issues:

Timelines are attached as Appendix 2.

- Plan for increasing hospital bed capacity to accommodate increases in admissions from an infectious disease epidemic over an extended period of time.

[13] CDC – HRSA Coordination, Bioterrorism Response Advisory Committee, Mary Selecky, Chair

- Plan for providing isolation and quarantine for casualties, using such references as CDC's for Type C (contagious) facilities.[5]
- Plan to address overcrowding and the need for hospital diversion, with large numbers of acute casualties arriving on their own or by ambulance, including a rapid communication plan with EMS units that allows them to determine a destination immediately at any time.
- Description of how hospitals will receive patients on a daily basis when several hospitals are on diversion simultaneously.
- Description of the plan for ensuring movement of equipment maintained by hospitals or EMS systems to the scene of a bioterrorist event.
- Description of how the special needs of children, pregnant women, the elderly and those with disabilities will be addressed in ensuring access to medically appropriate care. Planning for children should include school settings and the clinicians caring for them there.
- Description of how essential goods and services such as food, water, electricity and shelter will be delivered to patients and hospitals.
- Description of how hospital security will be provided (crowd control, patient traffic to support triage decisions, prevention of further terrorist attacks at the hospital).
- Description of procedures for safe and appropriate disposal of medical waste.

DOH and the HBPPC will create model hospital bioterrorism response plans to address each of the aforementioned issues. These plans will serve as templates for adoption within rural, suburban, or urban settings, and as a guidance document for regional hospital bioterrorism plan development. DOH and the HBPPC will coordinate with the parallel CDC Bioterrorism Plan's Bioterrorism Response Advisory Committee[14] and regional health jurisdiction coordinators to identify potential redundancies or additional questions regarding guidance for hospital plan development. DOH and the committee will coordinate with and integrate the hospital preparedness plan needs assessment results with these efforts.

In addition, DOH will contract with the Regional EMS and Trauma Care Councils to coordinate the development and implementation of regional hospital response plans. The Regional EMS and Trauma Care Councils are made up of local representatives from hospitals, emergency management, EMS, law, fire, and in some cases LHJs. Where LHJ representation is nonexistent, the region will be required to add

[14] CDC – HRSA Coordination, see Focus Area A (NPS)

representation.[15] It shall be the responsibility of the regional EMS councils to ensure collaboration with the regional health jurisdiction officer so as to ensure integration of CDC and OEP planning efforts. All regional hospital bioterrorism response plans must have the approval of the local health officer and local emergency management.* To ensure final integration with the state Comprehensive Emergency Management Plan as well revisions to ESF 8, regional hospital response plans will be reviewed and approved by state DOH and the state Emergency Management Department. Work plan timelines are attached as Appendix 2.

D. First Priority Planning Areas

Description of the intended approach to meeting priority needs:

1. Medications and Vaccines: Contingency plans for antibiotic and vaccine treatment of biological exposures including a practical action plan for tapping into Federal resources and a description of the State health department readiness plan for immediate receipt and distribution of antibiotics and smallpox and anthrax vaccines made available from Federal sources on a 24/7 basis:

DOH has taken the lead in the development of the state plan to implement the National Pharmaceutical Stockpile (NPS),* which is managed by the Centers for Disease Control and Prevention (CDC). In addition to DOH, many local and federal agencies have contributed suggestions and expertise during the process of Washington NPS plan development. The NPS includes pharmaceuticals, airway management supplies, IV fluids, surgical supplies, and other medical supplies. The first component of Washington's NPS plan is the12-hour "push package", which is maintained in specially designed air cargo containers in 8 (soon to be 12) strategic locations within the United States. These packages would be delivered within 12 hours to the State after the CDC approves its deployment and contain mainly bulk pharmaceuticals. The second component is called Vendor Managed Inventory (VMI). The VMI can deliver items such as specific repackaged antibiotics on an as needed or tailored basis.

After request and CDC approval, DOH would receive the NPS from CDC, manage any necessary repackaging, and distribute the repackaged pharmaceuticals to the Local Health Jurisdiction(s) (LHJs)[16] affected by the event, for dispensing. Local officials have the lead in dispensing the medications to those for whom treatment or prophylaxis is appropriate, and DOH will provide additional assistance as requested by the LHJ. In order for a local community to be prepared for such an event the local public health system is encouraged to plan ahead for such events by utilizing the adopted Dispensing Template. (See Tab E, below)

[15] CDC – HRSA Coordination, see Focus Area A, NPS
[16] CDC – HRSA Coordination, Local Health Jurisdictions, Focus Area A

The development and implementation of the Washington NPS plan is well underway. The plan has become part of the state's Comprehensive Emergency Management Plan as an appendix under Emergency Support Function 8, Health and Medical Services (ESF 8). The plan is divided into sections (tabs), which are individual stand-alone guidelines for a particular function of the Washington NPS plan. The draft tabs are in various stages of development and are organized as follows:

- **Tab A Roles and Responsibilities:** This tab assigns specific roles and responsibilities to federal and state agencies.
- **Tab B Decision Making Process:** This section provides guidelines used in determining if and when the Governor or one of the designees should request deployment of the NPS.
- **Tab C Preparing to Receive**: This section provides specific duties to members of the DOH, LHJ, L&I, CDC, as well as the local airport authorities and local police departments. (This tab outlines the specifics regarding facilities, personnel, and equipment required to receive the NPS push packages).
- **Tab D Managing**: This portion is under the direct control of DOH. However, it is at this step in the process that the LHJs become fully involved. The LHJ is to be responsible for assisting the state as needed with staff to expedite the repackaging and distribution of bulk supplies for delivery to LHJ dispensing sites.
- **Tab E Dispensing**: The lead for the Dispensing portion would be the LHJ in the affected area. The guidelines within the plan are intended to assist the LHJ setup a dispensing clinic and dispense the medications needed by potentially exposed persons, again with DOH assistance as requested by the LHJ. In order to dispense medications, a large number of qualified pharmacists and pharmacy assistants would are utilized, as well as other medical professionals and volunteers.

The current NPS plan dictates the state taking possession of NPS assets as soon as they arrive. From that point on the DOH operates the procedure for distribution. Vaccines, although not an official part of the NPS, will also be shipped to Washington State via NPS shipping procedures. A template is being added to the Washington NPS plan regarding establishment and operation of vaccination clinics during a biological or disaster incident.

Arrangements for tapping into other resources for antibiotic and vaccine treatment of biological exposures, such as pharmaceutical caches of metropolitan medical response systems funded by the Office of Emergency Preparedness, or other public and private sources:

Washington State does not currently have the planned Memoranda of Agreement (MOA) in place. DOH is currently working to develop and implement these Memoranda of Agreement with pharmaceutical cache owners and MMRS cities.

Justification for the composition of planned State and local antibiotic and vaccine stockpiles, on the basis of generally accepted clinical recommendations:

Please see the sections above regarding Washington State antibiotic and vaccine stockpile issues. The composition of the state/local stockpiles is currently being determined as part of the finalization of the Washington NPS[17] plan.

2. Personal Protection, Quarantine and Decontamination Plan:

The protection of clinicians and their families from exposures to biochemical casualties and environments will be addressed by DOH through identifying resource requirements and procedures needed to provide appropriate protection. This is an issue for incident first responders as well as clinicians, particularly for EMS, fire, and law enforcement personnel who are likely to be first in contact with chemical and biological agents. DOH will develop a plan to provide exposure protection to clinicians and first responders during FY 03.

Description of how existing decontamination systems will be upgraded to allow for large numbers of patients exposed to particulate infectious material from an airborne or environmental release:

DOH will conduct a risk assessment to determine the appropriate facilities for decontamination system upgrades. Based on the risk assessment, DOH will prepare a funding plan to upgrade existing hospital facility decontamination systems, including specifying individual facility upgrade requirements, and identifying the capital improvements to be addressed, by facility. The funding plan will be implemented and appropriate system improvements made during FY '03.

Description of which hospitals in the State will be targeted for capital improvements to assure safe and effective isolation and decontamination of large numbers of patients with communicable bioterrorist diseases:

[17] CDC – HRSA Coordination

DOH, in conjunction with LHJs and WSHA,[18] will conduct a demographics-based risk assessment to determine the appropriate facilities to be targeted for capital improvements in developing and implementing mass isolation and decontamination capabilities regarding patients with, or at risk for, communicable bioterrorist diseases, as well as concurrently undertake a review and revision of hospital licensing requirements in this area. Current Washington hospital licensing rules require a facility to have only one room of any size with negative air pressure capability for the management of airborne diseases, and a general "decontamination area" with shower and floor drain to sanitary sewage system adjacent to the facility emergency entrance. Licensing rules will be reviewed and updated as a part of this two-year plan to include requirements that address air-filtered quarantine units and biological decontamination capabilities. Local health jurisdictions will be included in the development of these hospital biological disease containment requirements, as well as in the determination of local alternative and quarantine treatment sites.

Description of how additional needed decontamination equipment will be deployed to maximize statewide benefit and cost-effectiveness including plans for mobile caches of supplies that could be deployed to areas with an acute need:

DOH will establish minimum requirements for PPE for licensed hospital facilities. While each facility will be required to obtain PPE and to train employees in the appropriate use of PPE, DOH will also undertake a study of the use of alternative methods to make large quantities of PPE available to hospitals across the state on short notice, including centralized stockpiling, caching, and mobile supply capabilities.

3. Communications: The needs assessment will address existing local and State communications capabilities available to hospitals and collaborating entities, and the ability of the statewide communication system to respond to overloading of standard telephone, cellular phone and radio communications during a bioterrorist incident resulting in mass casualties.

Description of how the State bioterrorism hospital preparedness program will be activated during an acute incident, or one involving an epidemic developing over a longer time period:

Washington's regional EMS and trauma system includes key hospitals that are capable of functioning as "hospital control" for the region. These "hospital control" facilities relay key information and act as single points of activation for the state

[18] CDC – HRSA Coordination, see Focus Area A

bioterrorism plan. Typically "hospital control" facilities are level two trauma centers. These hospitals will be equipped with communications technology to interface with local and state emergency management agencies. The state EOC is operational 24 hours a day, seven days a week, year round to initiate or monitor these communications. Incorporating two additional regions to support the population and communications demands will enhance the "hospital control" plan. Additionally, contingency plans will be developed to interface with the Portland area and the Oregon State Health agencies. Further plans include cooperation with the cities of Victoria and Vancouver in British Columbia, Canada to for seamless health implementation across the international border, if required.

The plan for addressing gaps in the communications systems among hospital emergency departments, outpatient facilities, EMS systems and State and local emergency management, public health and law enforcement agencies, as they relate to bioterrorism response:

The state of Washington is in the process of implementing a multiple tier health communications system.[19] This system is based on:

- Telephone communications with web-based directory of public health emergency response officials.
- Planning to assure redundancy of communications at all levels including trained volunteer amateur radio operators.
- Using a statewide web-based hospital bed capacity, emergency department status and supplies status as a common tool for all health and public safety providers.
- Using the trauma system and other key hospitals as regional "hospital control" facilities.
- Utilizing the 24-hour state EOC and its communications infrastructure for liaison with local EOC's, health and "hospital control" facilities.
- Utilizing the Hospital Emergency and Administrative Radio (HEAR) for local communications among EMS, hospital and "hospital control."
- Implementing a statewide UHF radio system for all hospitals and public safety agencies as a common statewide health communications network.
- Utilizing the state Department of Transportation radio system for a radio system specific to Health Department needs (CDC Initiative funding).
- Active participation and planning in future (700 megahertz) state radio system at the LHJ and hospital trauma levels.

[19] CDC – HRSA Coordination, see Focus Area E, Health Alert Network

- Utilizing existing Emergency Management structure with Public Information Officers (PIOs) and Joint Information Centers (JICs) to support media, public relations and educational messages for general public.
- Web based training package for hospital communicator "certification" to be able to adequately use the communications tools provided.

Washington State has several systems in place that will be expanded and added to hospital, EMS, and health agencies to incorporate a cohesive communications system. This plan is based on funding levels to be approved and available. DOH, key LHJs in major population centers, and all level two trauma centers will have access to the state Emergency Management communications system. Hospitals, LHJs, EMS and other agencies may participate in the planned statewide UHF radio system. This system allows local select access as well as statewide communications for any patient related health emergency.

As part of the CDC bioterrorism proposal, DOH has recommended that an LHJ radio system be initiated for Washington State.[20] This system will use two statewide talk groups on the DOT 800 radio system. One talk group will be for all LHJs to have common communications, the second talk group will be an administrative talk group specifically for DOH for statewide coordination as required in a bioterrorism activity. Law enforcement and other agencies will be linked via the "hospital control" and state EOC. Future plans for implementing a statewide 700-radio system will further improve this level of interoperability. Both the Governor's EMS and Trauma Care Steering Committee and DOH are represented on a state interoperability planning committee. Other agencies include WSP, Natural Resources, Transportation, the Department of Defense and other federal agencies.

Description of how communication systems will be made redundant, to ensure communication backup in the event of failure or excess load on landline and cellular telephone systems and Internet communications:

The primary means of communication among health entities is telephone communications. These means are already redundant in many hospitals. An on-line phone book is currently maintained and will be expanded on the hospital capacity web page. Information from the hospital community contained in this book will also feed the state's automated public health directory.

[20] CDC – HRSA Coordination, see Focus Areas F and G

In addition to telephone communications, all communication protocols are determined by asking, "who are you going to call and how do you contact them if not by telephone". DOH is also proposing utilization of the existing statewide HEAR radio system to assure communications between hospitals. This will assure that hospitals have a minimum of two commercial communication mediums. Moreover, Washington is fortunate to have a significant amateur radio presence, including volunteer organizations specifically supporting hospitals. To support this system, a common amateur radio array will be provided to all hospitals.

Select locations will have access to the state 800-radio system as well as the state satellite and Emergency Management radio systems, and to the web page for exchange of information. To assure hospitals and health agencies know how to use all of these communications modalities a "hospital communicator" curriculum will be implemented. This will be a web-based class that will allow any approved public safety or registered emergency worker to become familiar with the communications capabilities available to hospitals.

All of the voice-based communications systems described above will be integrated with the Washington State Electronic Communication, Urgent Response and Exchange System (WA-SECURES) as part of the CDC Bioterrorism Initiative. WA-SECURES will integrate commercial off-the shelf software applications (Microsoft Share Point, Content Manager, and COM 2001 Alexis) with an integrated statewide role-based directory to allow for a secure web portal that will replace the functionality of listserves with the ability to place conference calls with appropriate state and local public health officials on a demand basis, as well as targeted and broadcast FAX, email, page, and text messaging alerts. This application will allow for a secure and virtual collaboration with anyone in the public health emergency response system via the use of the Internet. WA-SECURES will be deployed in stages, first to state and local public health agencies, then hospitals,[21] members of the Laboratory Response Network, emergency management agencies, and law enforcement agencies in phased increments. WA-SECURES will use the underlying directory of public health emergency response officials to locate them 24 hours a day, seven days a week. Should an identified official not be reachable, WA-SECURES will use the directory structure to ensure contact with the designated back-up official.

[21] CDC – HRSA Coordination, Focus Areas E and B

The plan for electronic tracking of bed status across the State with a central device or system, and how this information will be updated continuously to maintain currency:

The Puget Sound basin currently has a web-based secure and password-protected means of managing bed counts and information among hospitals and other public safety authorities. This web page will interface with other web-based systems statewide. This web page is sponsored by the state's Level One Trauma Hospital Harborview Medical Center in conjunction with the University of Washington. The University is a major hub for Internet activities, including future technology. They also have other resources to assure a reliable, secure and redundant web site to meet state needs. This web site is operational and may be viewed by the Federal agencies at any time via request for password.

The plan for monitoring all emergency department and outpatient visits, complaints, and diagnosis from a surveillance and detection perspective, and how this will be integrated on the State and national level and the plan for how this will be funded with CDC surveillance money in constructing an integrated plan:

PHSKC had been working with the University of Washington prior to 9/11 to develop and implement a pilot monitoring system that would automatically collect such data as emergency department (ED) visits, diagnosis, pharmacy requests, and similar information. While this system is still in its development and testing phase, it already possesses the correct interfaces to collect the data required. CDC Public Health Preparedness and Response for Bioterrorism[22] funds will be used to continue development and evaluation of this system.

With the exception of the PHSKC pilot monitoring system, above, capacity for statewide monitoring of all emergency departments and outpatient visits does not currently exist within Washington State. Consequently, Washington is unable to integrate such syndromic surveillance with other surveillance activities at the state or national level. DOH will coordinate the efforts of the CDC needs assessment and planning activities with HRSA* grant activities to determine the appropriate methodologies for addressing this issue on a statewide basis, including potential adaptations from the Seattle/King County pilot monitoring system or development of other syndromic surveillance systems.

[22] CDC – HRSA Coordination, Focus Areas E and B

The general public will be educated as to where and when to present to the hospital or to activate EMS.

Due to wildfires and other emergency management activities, PIOs in Washington State are familiar with and work routinely in combined JICs. These centers are typically managed in conjunction with the local Emergency Management organization. The rural nature of most of the state means that there are relatively few TV media outlets. These can be educated and informed of events in a quick and cohesive manner. DOH will work in conjunction with the WSHA[23] to arrange meetings and information exchange as required to support this media and educational activity.

The communications system plan includes issuing frequent news releases and holding news conferences as appropriate to provide accurate up to date information to the public. The goal is to give the public, via the media, messages that will reduce rumors, anxiety, and fear, while also providing useful information to help potential disease victims decide if they should come to a hospital. An additional part of the communication system plan includes risk communication strategy training for local health officials and others, including hospital communicators.

The public relations plan for dealing with large numbers of patients, worried well, family and friends, and media:

In coordination with the DOH Communications Office Management Team[24] and incident-related DOH divisions, DOH PIOs, the DOH Web Team, and DOH Emergency Communications Roster staff will assume emergency assignments during a biological or other disaster incident, with the following responsibilities:

- Media Response Coordinator – Track and log all media calls, inquiries and response efforts; record key and emerging issues, answer staff and LHJ inquiries regarding status of interviews, information distribution efforts, and issues.
- Public Information Officers and Emergency Communications Roster staff – Create or distribute press releases, talking points, background information, fact sheets and other materials as assigned. Respond to general inquiries from media/staff/LHJ/public health and system partners. Provide

[23] CDC – HRSA Coordination, Focus Areas F and G
[24] CDC – HRSA Coordination, see Focus Areas E and G

division/program and LHJ media assistance as needed. Provide research assistance.

- Web Management Team – Coordinate intranet (employee communications), media and general public messages (internet), and LHJ/provider/emergency responder alerts and information (internet). Ongoing Web updates and message maintenance. Work with DIS in the event of DOH Web server failure.
- Administrative staff support – Broadcast fax news releases and other information—as appropriate—to state media list, LHJs, and designated hospitals/regional medical centers; materials preparation support; general inquiries; other duties as assigned.

Communications Office/Emergency Plan Logistics:

The emergency communications plan will be coordinated from the DOH Communications Office in Olympia. Emergency media hotline system is in place with all Communication Office lines streaming to one number when activated. (Additional lines as needed.)

- Existing Communications Office phone numbers will automatically transfer to central hotline.
- Central hotline number will be distributed to media, LHJs, partners.

There is a plan in place to move Communications Office phones and functions to different building if security/integrity of current location is threatened. An Emergency Web posting agreement with DIS exists in the event of DOH server failure. In addition, if required, DOH emergency communications staff—on limited priority basis—can be deployed to affected region (LHJ or JIC).

4. Biological Disaster Drills: Practical exercises and a description of the plan for testing State and local bioterrorism response plans and for reinforcing training efforts:

DOH, LHJs, local emergency management agencies, local hospitals, and EMS agencies will conduct at least one bioterrorism incident response tabletop exercise in each county in the state during FY 03.[25] These exercises will focus on bringing forward those areas in which cooperation and coordination between the agencies involved is functioning at less than optimum, and developing and implementing within

[25] CDC – HRSA Coordination, see Focus Areas A and B

the local systems specific solutions to positively address those issues. Training in bioterrorism response issues for local agency healthcare providers and personnel will subsequently be tailored to address those gaps in response and capacity as identified in the exercise, as well as reinforce current initial and continuing training for bioterrorism incident first responders and healthcare professionals.

A description of how biological disaster drills will be of sufficient intensity to impact the community's normal operations during the exercise:

Biological disaster drills will be developed and conducted by DOH, LHJs, local emergency management agencies, hospitals, and EMS providers.* As developed, these drills will require actual physical response from the agencies involved to the scene, determination of patient contagion at the scene, the care of contagious patients at the scene, transportation of contagious patients to the facility, and receipt by the facility of multiple contagious patients. The drills will also involve activation of the county (and state) EOCs, and the management of the incident under emergency conditions from the county and state EOCs.

The process for incorporating lessons learned from the drills into periodic revisions of the bioterrorism response plan:

The participants immediately following the drill, including DOH, will make a determination of lessons learned jointly. A specific plan will be developed jointly by the participants to address each of the lessons learned, with responsibility for developing and implementing the appropriate action regarding each lesson assigned to the appropriate participant. These actions and their implementation will then be formally reviewed jointly by the participants and DOH, and incorporated into the local and state bioterrorism response plans.

E. Second Priority Planning Areas

1. Personnel: Description of how additional hospital and EMS personnel will be recruited and deployed at the local level to implement an effective medical bioterrorism response plan:

DOH has been working closely, over the past six months, with the WSHA, WSMA, WSNA, WSFCA, WACMHC and other state healthcare professions groups, to address the issues of healthcare professional recruitment and deployment during bioterrorism and other disaster situations. Meetings with these professional

groups and staffs have focused on determining methodologies for recruitment and deployment of healthcare professionals in response areas, licensing and credentialing issues involved, organization of personnel and equipment prior to deployment and at the response scene, and transportation, field support, and other associated issues. State and local disaster response plans also include the specific response capabilities and activation procedures for MMRS and Disaster Medical Assistance Teams (DMATs), but do not currently address the issues of further additional healthcare professional recruitment and deployment to meet a standard deployment capability of 50 healthcare professional in urban areas or 20 professionals in rural areas. DOH and the state healthcare professions associations will develop and implement the plan for healthcare professional recruitment and deployment to this standard prior to the end of FY '03.

The plan for ensuring support for hospitals and EMS systems through mutual aid agreements, metropolitan medical response systems or disaster medical assistance teams:

The development and implementation of mutual aid agreements between public and private EMS agencies during mass casualty or disaster incidents has been an integral part of local and regional EMS system planning in Washington over the past ten years. Regional EMS and trauma care councils have worked closely with county EMS and trauma care councils and local EMS provider agencies to develop and implement mutual aid agreements covering activation, deployment, and reimbursement to deploying agencies for operational costs associated with such deployment.[26]

These local mutual aid agreements, primarily between fire agencies for providing reinforcement fire and EMS services, have been created under the umbrella of the Washington Fire Mobilization Act. DOH has discussed supporting the introduction of similar state legislation, a Washington EMS Mobilization Act, during next legislative session to enable fire and EMS agencies to provide more channeled and focused support in the EMS mutual aid area.

In the context of EMS mutual aid agreements, MMRS and DMAT teams currently function as a significant but parallel portion of the initial response to a biological or mass casualty incident, rather than more appropriately as an integral component part of any particular current mutual aid agreement. This is possibly due in large

[26] CDC – HRSA Coordination, see Focus Area A

part to the perception of these teams as being "outside" the regular fire and EMS response systems. During the next year DOH will work with the Washington Fire Chiefs and other professional associations to develop and implement a Washington EMS Mobilization Act to include addressing the mutual aid and professional response team integration issues, discussed here, on a direct basis.

The plan for license reciprocity, credentialing and supervision of clinicians not normally working in facilities responding to bioterrorism: Please refer to Section B.

The plan for managing unsolicited offers of help from undocumented clinicians arriving in a biological disaster area:

Please see reference above. DOH is reviewing additional possibilities regarding clarification of these issues, possibly including mutual aid agreements among local public health jurisdictions, as well as coordination with the federal resources regarding the availability of Medical Reserve Corps volunteers.

2. Training: Training of hospital and prehospital clinicians at all levels:

DOH plans to address three primary areas regarding training delivery capacity for hospital and EMS clinician bioterrorism event response; (1) human resources for instruction, coordination and learning support; (2) technology for blended learning; and (3) funding subsidies to reduce barriers to participation.

The plan for training and educating hospital and EMS clinicians to respond to a bioterrorism event, including components for managing fears about personal exposure to biological agents:

The Training Subcommittee of the Washington State Committee on Terrorism (COT) identified approximately 98,000 first responders who require weapons of mass destruction (WMD) awareness level training alone. This does not include WMD responder operations, technicians, EMS, hospital providers, public health providers, incident command level training or public health training. The human resource capacity for training across all sectors is severely limited to meet this level of need.

DOH, through existing training contracts, conducts local and regional first responder prehospital and hospital personnel training throughout the state, with

very limited state funding.[27] Regional EMS and Trauma Care Councils currently receive this limited funding from DOH to coordinate and conduct training at the local and regional levels for EMTs, Paramedics, nurses, doctors, and other healthcare professionals in the areas of emergent patient care, trauma patient care, mass casualty incidents, personal exposure fears, and general biological and chemical agent response. Training specifically oriented to bioterrorism, WMD, and disaster response for prehospital and hospital healthcare providers is currently being developed and updated by appropriate resources including academic institutions, healthcare provider associations, and traditional regional and local training provider institutions.[28]

The DOH bioterrorism planning effort in Washington anticipates the use, to the maximum extent possible, of the existing, limited regional/local EMS and trauma care education and training resources across the state. These regional and local education and training systems have capacity for expansion to help undertake a lead role in implementing new, and expanding current, learning strategies and methods across the state, as well as having experience in the education and training of large numbers of healthcare personnel to respond to all levels of disaster, including multiple casualty incidents.

The existing State or national training resources that will be utilized in developing the State's bioterrorism training program:

Regional and local prehospital and hospital personnel training is currently being conducted throughout Washington State using a variety of mediums, including distance-learning, internet, and web-based courses as well as in traditional classroom settings.* This training is coordinated and operates in conjunction with, the state community college and university systems, which help provide ongoing teaching, training, and technical support to the local and regional prehospital and hospital education and training systems. Instruction, education coordination, and learning support for prehospital and hospital healthcare professionals is also available through the eight existing regional EMS and trauma care councils ongoing education and training components, which include approximately 300 Senior EMS Instructors plus a large number of lecturers, evaluators, and other learning support staff at the local and regional levels. Additionally, the Fire Education Training Network (FETN) as well as the larger Washington cities (Seattle, Tacoma)

[27] CDC – HRSA Coordination, See Focus Area G
[28] CDC – HRSA Coordination, see Focus Area G

utilize closed circuit television systems as well as traditional settings to provide prehospital personnel training within their organizations.

The primary human resources available for statewide prehospital and hospital personnel learning support currently exist and are coordinated through the established regional and local EMS and trauma education and training systems. These resources include a didactic as well as hands-on training capacity, with a minimum of technological support currently available particularly in rural areas. Sufficient resources from state and local levels, however, have been unavailable for expansion of distance learning technologies, and to support web development for expanded learning support.

Reducing barriers to training opportunities is a key issue for training provision in bioterrorism and disaster response in Washington State.[29] DOH is able to subsidize some distance based training but it is limited primarily to satellite productions through the CDC Public Health Training Network. DOH also subsidizes the Public Health Core Functions training offered to the local/state health workforce. However, other learning methods and strategies that could be developed as web applications (i.e. searchable repositories of best practices, Bioterrorism curriculum, human expertise, etc) have yet to be developed due to lack of resources.

DOH also contracts with regional EMS and trauma care councils to support a minor capacity for education and training for hospital and prehospital personnel at the regional and local levels. Additionally, DOH contracts for prehospital and hospital personnel training traditionally provide funding for training only, with no subsidization for other costs (wages, travel expenses) associated with the training. Additional resources are needed in these areas.

The plan for developing or updating diagnostic and treatment protocols for bioterrorist infectious diseases and toxins with early nonspecific syndromes with priority given to: Bacteria: anthrax, brucellosis, plague, Q fever and tularemia, Viruses: smallpox, equine encephalitis, and hemorrhagic fevers, Toxins: botulinum, staphylococcal enterotoxin B, ricin, and T-2 mycotoxin:

The plan for developing or updating diagnostic and treatment protocols for bioterrorist infectious diseases is to collaborate with the CDC Bioterrorism Proposal staff team[30] to develop said protocols in consistent manner for use in

[29] CDC – HRSA Coordination, see Focus Areas G and C
[30] CDC – HRSA Coordination, see Focus Areas G and C

emergency department, outpatient and inpatient facilities, ICUs, and prehospital environments. These protocols will draw on the expertise in the DOH Office of Communicable Disease Epidemiology and the state Public Health Laboratory* and build on previously developed materials from the CDC, DOH and other relevant information sources.

In response to events of 9/11, the DOH Office of Emergency Medical and Trauma Prevention in issued a guide for certified prehospital personnel, in December 2001, addressing biological and chemical weapon response information for EMS personnel, including diagnostic and treatment information. This guide has been distributed to all licensed and verified EMS agencies, county EMS Medical Program Directors, regional EMS and trauma care councils and administrators, county EMS offices, and Senior EMS Instructors in the state, as well as being available for downloading in it's entirety from the DOH\EMTP website. The guide includes information on and directly addresses potential exposure to/contact with bacterial agents, viruses, and toxins.

Although developed specifically for use by prehospital personnel, the guide also contains information relevant to emergency department and hospital personnel, and has been distributed within hospitals and to emergency department personnel as well. The information in the guide includes basic information on the biological and chemical agents most likely to be found in the field (see above), common syndrome information, and agent-specific facts sheets. The guide also contains updated bioagent infection control measures (including standard precautions, airborne precautions, droplet precautions, and contact precautions), a ten-step schedule for handling possible bioterrorism events, and both biological and chemical agent quick reference outlines.

In the coming year, DOH will integrate web-development efforts so that terrorism information for local health officials, prehospital and hospital providers, clinicians, and other key individuals and organizations is presented in a consistent and predictable manner in a common, secure location.[31] This will assure consistency of content and will allow the agency to rapidly assess and respond to emerging needs. DOH plans to continuously update the information available from its website for prehospital and hospital providers, as well as to incorporate continually updated biological and chemical agent response information into its healthcare provider training, education and CME content over the next two years.

[31] CDC – HRSA Coordination, see Focus Areas F and G

Since 9/11, both WSMA and WSHA have developed and maintained detailed biological and chemical agent diagnostic and treatment information on their websites, as well as distributing this information to their memberships and other healthcare professionals statewide. These activities will be coordinated with DOH efforts to assure consistency in information and the broadest possible dissemination.

A description of how special issues affecting children, pregnant women, the elderly and those with disabilities will be addressed in these protocols:

DOH is currently in the process of developing models for additions to in-place prehospital and hospital protocols, which address the general population, children, pregnant women, the elderly, and special needs groups, regarding their during biological and chemical agent incident response by prehospital and hospital personnel.

A description of how immediate information needs experienced by clinicians caring for patients or serving as EMS medical control officers will be addressed during a bioterrorist incident:

Please see plan for developing and updating diagnostic and treatment protocols for bioterrorist infectious diseases and toxins with early nonspecific syndromes, above. The Office of Communicable Disease Epidemiology (OCDE) has a 24-hour contact number for clinicians who may be confronted with a potential bioterrorist incident.[32] During the anthrax events of October and November 2001, OCDE established a call center where clinicians, first responders, and others could obtain expert guidance on appropriate diagnostic and treatment protocols. Plans are being developed to enhance OCDE's surge capacity so that a similar service can be offered during a large-scale event.

As with WSMA and WSHA (see above), DOH plans to continuously update the information available from its website for prehospital and hospital providers, as well as to incorporate continually updated biological and chemical agent response information into its healthcare provider training, education and CME content over the next two years.

[32] CDC – HRSA Coordination, see Focus Area B

The plan for enhancing the ability of poison control centers serving the State to respond immediately to requests for information from clinicians and the general public following a bioterrorist incident:

The Washington Poison Control Center, funded by DOH, has recently undergone several technological changes designed to improve and increase its ability to respond to questions from the general public, including phone system and call answering improvements, and public dissemination of a new 24-hour statewide hotline telephone number. DOH will continue to work with the Poison Control Center to establish a separate telephone contact system for use specifically by clinicians and healthcare professionals regarding bioterrorism information requests. The Poison Control Center will also participate in the needs assessment and planning process in order to specify their current ability and increase their future capacity to respond immediately to clinicians during bioterrorism or disaster situations.

The plan for ensuring continuing professional education credentialing of in-services or conferences on bioterrorism:

Each licensed and certified profession in Washington State has its own requirements for continuing education. Practitioners may currently take general courses in bioterrorism preparedness or recognition and receive CME credit towards their Washington State continuing education requirements. If a determination were made to specify a type of continuing education, i.e., bioterrorism preparedness, state legislation would be required to implement it. The only across-the-professions requirement currently in effect for healthcare professionals in the state is HIV/AIDs training. In addition, some health professional associations are less than supportive of requiring additional continuing educational content. DOH, however, will coordinate this area with the state healthcare provider associations as well as the University of Washington Northwest Center for Public Health Practice,[33] to create a plan to make bioterrorism education and certification courses available to healthcare professions in Washington State, and to create linkages to national and appropriate military resources as available. DOH will also build on current relationships with the University of Washington School of Medicine to assure that bioterrorism-related training is offered to clinicians at every stage of their professional development.

[33] CDC – HRSA Coordination, see Focus Area G

The plan for a statewide bioterrorism education and certification program for clinicians, or a plan for linking the State's efforts into similar available national programs, including those of the military: Please see section above.

3. Patient Transfer: Hospitals will be evacuated in the event of a bioterrorist attack, and the hospital patients will be housed to ensure safety and good medical care.

DOH will conduct an assessment of current individual hospital requirements and current hospital plans, regarding patient handling and sheltering issues during bioterrorism and disaster incidents, including plans for special needs patients. Based on this assessment and with input from the Bioterrorism Hospital Preparedness Planning Committee, DOH will work with individual hospitals, including using model plans, to develop, upgrade, and implement plans for hospital evacuation, patient triage, EMS transport of patients, and alternative housing options for mass casualties during bioterrorism or disaster incidents, including plans to address special needs patient populations.

Patients could be triaged to make additional hospital bed space available during a terrorism event.

Each referenced hospital assessment and plan will include patient triage and alternative patient housing options. For further reference, see the section above.

A description of how hospitals and EMS will deal with patient transports and destinations associated with a communicable disease:

DOH-approved PCPs, and COPs currently in place across Washington State provide a guideline and blueprint for the EMS system regarding patient transport and patient destination under all circumstances, including patients with communicable diseases. Beginning July 1, 2002, DOH will include in its annual contract with the eight regional EMS and trauma care councils, new contract deliverables designed to ensure a complete review of regional/county system operations, and specifically requiring regional PCPs and county COPs to update and address in detail their EMS system operation requirements regarding transport and destination requirements for single and multiple communicable disease patients.

The plan for using non-hospital facilities to shelter and treat mass casualties or epidemic victims if hospitals are overwhelmed:

Each referenced hospital assessment and plan will include patient triage and alternative patient housing options. For further reference, see the section above.

The needs of children, pregnant women, the elderly and those with disabilities will be addressed during patient transfers.

Current county EMS protocols, as well as county COPs, address the issue of special needs patients during patient transfers. During FY '03 DOH will request EMS County Medical Program Directors to review and update their current county PCPs regarding special needs patients and special needs patient transfers, and will provide technical assistance to Medical Program Directors in this area as requested or required.

The role of schools in a bioterrorism incident; as potential targets, as facilities for emergency shelter or quarantine, and as resources for clinicians such as school nurses who may be assigned there:

Schools are potential targets of bioterrorism. Over the past four years, the Washington Office of Superintendent of Public Instruction (OSPI), has offered grants to schools to increase security and develop individual school plans for responding to the issues raised by a possible attack against the school, or against the community in which it is located. These plans, however, have been primarily internally oriented to the school, and have not addressed the larger question of the potential role of the school building(s) as shelters or quarantine areas, nor have they addressed the use of school staff (nurses) working there. DOH and LHJs[34] will address these potential building-use and school staff role issues with OSPI staff and school administrators, and incorporate their appropriate use into the state incident response plan, during FY '03.

F. Infrastructure

In order to ensure an adequate infrastructure to support the planning and implementation process, the following will be addressed in Phase 2:

1. Staffing and Medical Direction:

[34] CDC – HRSA Coordination, see Focus Area A

Medical guidance and expertise in the development of Washington's Bioterrorism Preparedness plan will come from a multifaceted and inclusive approach to planning, decision-making and implementation. Key physician partners with the medical expertise expected to provide regular and ongoing guidance include:

Washington State Medical Association (WSMA)- Disaster Preparedness Committee and EMS Standards Committee: These two physician-staffed subcommittees have the most direct relationship to activities associated with hospital bioterrorism preparedness. Their counsel will be routinely sought so as to ensure bioterrorism plans and implementation efforts are medically and operationally sound.

Washington State Hospital Association (WSHA)- Disaster Preparedness Committee: WSHA regularly convenes their Disaster Preparedness Committee to find methods for improving hospital capacity to respond to a major disaster. This Committee's input is crucial to the process of determining hospital needs and methods for improving bioterrorism plans. A member from WSHA is included on Hospital Bioterrorism Preparedness Planning Committee to ensure the Disaster Preparedness Committee's input is included in assessment and planning efforts.

DOH Certified County Medical Program Directors: Each county currently has a DOH certified physician medical program director (MPDs) responsible for assuring medical oversight for over 17,000 certified EMS personnel statewide. Medical oversight includes protocol development and compliance, training approval, continuing medical education approval, and providing input on the development of regional patient care procedures that help to assure patients are transported to the right facility. These MPDs are emergency department physicians recognized throughout their communities for their ability to build and maintain relationships between area hospitals, the EMS system, law enforcement, and local emergency management. DOH intends to utilize this existing infrastructure of medical oversight as a means to build upon existing capacities while implementing regional hospital bioterrorism preparedness plans which include, training, protocol development, and the routine practice of bioterrorist exercises.

The role of the medical director or designee in providing expert guidance to the State bioterrorism preparedness program, and the education, training and experience that prepares this person for the task:

In addition to the use of this existing infrastructure of local and regional oversight, DOH will seek medical expertise and guidance in the development and implementation of its bioterrorism preparedness plans through the following means:

Medical Director - A physician medical director provides medical consultation and guidance to the Bioterrorism Hospital Coordinator. The medical director who is also a member of the Washington State Medical Association, will work collaboratively with the DOH Senior Public Health Official and the Bioterrorism Coordinator to:

- Provide medical consultation and guidance to the Hospital Bioterrorism Preparedness Planning Committee and the State Bioterrorism Preparedness Planning Committee[35] in planning and implementation efforts directed toward increasing hospital preparedness in:
    - Temporary credentialing of healthcare providers to provide services in hospitals during a bioterrorism event or other public health emergency;
    - Recruitment and training of healthcare practitioners;
    - Managing and mobilizing healthcare practitioners to respond to a bioterrorism event.
- Assure integration of hospitals with National Pharmaceutical Stockpile program; [36]
- Assure appropriate medical content and practice in hospital bioterrorism plans, protocols, and training curricula for healthcare practitioners;
- Liaison with the Washington State Medical Association, the Washington State Hospital Association and other healthcare entities; and
- Work with professional organizations to promote direct integration of bioterrorism awareness objectives into medical school, nursing education and EMS provider curricula.

The medical director for the Washington State Hospital Bioterrorism Preparedness Program will be Dr. Nancy Auer, Vice President for Medical Affairs, Swedish Health Services in Seattle. Dr. Auer is past president of the WSMA and chair of its Executive Committee. She has been very active in WSMA affairs for several years, serving as Secretary/Treasurer, first vice president and president-elect prior to being elected president of the association in 2000. Dr. Auer

[35] CDC – HRSA Coordination, see Focus Area A
[36] CDC – HRSA Coordination, see Focus Area A (NPS)

received her medical degree from the University of Tennessee Medical School. An emergency physician by training, she is currently the Vice President of Medical Affairs at Swedish Medical Center. Dr. Auer has been with Swedish since 1980 and has over 20 years of clinical and administrative experience.

Dr. Auer was the first woman President of the Washington Chapter of the American College of Emergency Physicians. She followed that achievement in 1998 by becoming the first woman President of the American College of Emergency Physicians (ACEP), her national professional organization. She is President of the International Federation of Emergency Medicine, and serves as chair for the Emergency Medicine Foundation. Dr. Auer is also a member of the Section on Disaster Medicine within the American College of Emergency Medicine. She was a member of the Steering Committee for National Disaster Medical System that created DMATs in 1992 and served as the medical director of Seattle King County Disaster Team since 1990. She currently serves as Chair of the Task Force on Bioterrorism for the American College of Emergency Physicians and for the WSMA.

It is anticipated that the Medical Director will proactively communicate with the medical program directors, local health officers, and local emergency managers by providing regular updates on the status of bioterrorism hospital preparedness plans statewide.

The role of the State EMS director in the bioterrorism hospital preparedness program administered by the State health department:

State EMS Director Role - The state EMS Director is expected to provide guidance to the Bioterrorism Hospital Coordinator and the Hospital Bioterrorism Committee on the best methods for integration of hospital bioterrorism planning and implementation efforts with Washington's eight EMS and Trauma Care regions and the statewide system of designated trauma facilities. As regional hospital planning occurs Committee members will be asked to consider utilizing the existing regional EMS and Trauma care system as an infrastructure worthy of building regional hospital bioterrorism planning efforts. The state EMS Director will play an important role in helping Committee members understand how the existing regional EMS and Trauma care system can be utilized for current and future planning efforts, needs assessments, protocol development, a healthcare practitioner

training coordination and delivery system, and most importantly a forum for improving local, regional, state and federal partnerships.

There is a need for support personnel to administer the cooperative agreement, and the training and experience possessed by these people.

To ensure efficient and comprehensive monitoring of cooperative agreements support staff are necessary to perform the following functions:

Bioterrorism Health Services Consultant 3 - The hiring process to fill the position of Bioterrorism Health Services Consultant 3 is currently underway. The person hired will have qualifications, which will enable them to fulfill the following duties:

- Implements and monitors funding to hospitals and other healthcare entities via contractual arrangements;
- Through data collection, monitors quality improvement program and assures compliance with performance measures identified in contractual arrangements;
- Assists medical director and bioterrorism coordinator in hospital integration with the National Pharmaceutical Stockpile program; [37]
- Provides technical assistance to hospital community in the implementation of preparedness plans and protocols;
- Assists medical director and bioterrorism coordinator in the enhancement of a data base infrastructure for bed capacity and alternate facilities identification;
- Facilitates and promotes the development of hospital partnerships between local health jurisdictions, local emergency management, and local EMS systems;
- Coordinates with the bioterrorism hospital coordinator the integration of the appropriate Critical Benchmarks for Bioterrorism Preparedness Planning criteria in plan development and implementation; and
- Coordinates activities pertaining to informing, educating, and mobilizing healthcare practitioners to recognize/treat/control bioterrorism-related illness.

[37] CDC – HRSA Coordination, see Focus Area A (NPS)

2. Coordination and Collaboration: The roles of local, Tribal, Federal and military hospitals, referral centers, EMS systems, and outpatient facilities, and how they collaborate through such mechanisms as mutual aid agreements and regional or multistate consortia:

Washington State has addressed inter-system, inter-governmental, and inter-agency coordination and collaboration issues involved in disaster response issues over the long term through (1) state and local emergency management plans, and (2) regionally-developed and state-approved regional EMS and trauma care plans. While these plans form the foundation for the state disaster and biological response capability, they have been primarily developed and implemented in the past with an emphasis on non-biological disaster response areas. In general, these plans describe and direct the emergency response in their coverage area, and reference and incorporate existing mutual aid agreements into their plan operational specifications. The role of local, tribal, federal, and military hospitals in this disaster planning has previously been overshadowed by a primary focus on the development and organization of a disaster first response capability.

DOH Hospital Bioterrorism Preparedness Planning Committee will be the primary means of insuring hospitals and primary care facilities at every level are included in current and ongoing planning for bioterrorism and disaster response in Washington. The roster of the Committee members as listed above includes, among others, the WSHA, WASMA, WASNA, Madigan Army Medical Center, WSALPHO, Association of Washington Public Hospital Districts, WACMHC, Harborview Medical Center, and the Washington State Office of Indian Affairs. Input and buy-in from these organizations and institutions is considered essential to both the development and implementation of hospital preparedness activities in the state, and as an integral part of planning for disaster response at the local, regional, and state level.

Beyond participation in their overall policy role described here, these organizations and their constituencies also represent their individual roles in local and regional disaster response planning efforts at the local EMS and emergency management levels, as well as at the local and regional levels through their participation in the development of regional EMS and trauma care plans. At both these levels the emphasis on disaster response planning is now shifting to include a new focus on the needs of the local and regional systems to prepare for response to bioterrorism incidents as well as non-biological disaster incidents, and the revision and expansion of current emergency response plans to include hospital preparedness needs and activities as an integral part of the biological and disaster system response.

Knowledge of bioterrorism preparedness resources on the local, regional, State and national level:

Please see sections (A) Background and History, and (C) Critical Benchmarks, above, which detail the current activities and specify the current resources at the local, regional, state, and federal levels which have been accessed and are included in current collaborative Washington State biological and disaster incident response activities, as organized under the umbrella of the Governor's Emergency Management Council and the EMC's Committee on Terrorism. These active resources specifically include state and local EMS organizations, healthcare professional organizations, the Washington Poison Control Center, MMR and DMATs, federal and tribal and community healthcare facilities, and local, state, and federal emergency management agencies.
In addition, since 9/11, DOH has conducted an extensive review of information regarding biological and disaster incident response issues. This review was conducted in order to acquire as complete a body of knowledge as possible regarding the current state of biological and disaster response preparedness across the nation, and to realize the benefits of the most current theory and best practices efforts of other states and organizations in the areas of biological and disaster incident response. The theories and best practices found have been reduced to four potential system models, and DOH plans to use the information gathered in this review to compare and assess these models of biological and disaster incident response in order to determine which model(s), or parts of models, are the most suitable for modification to Washington State's biological and disaster response needs.

Letters of support are included outlining specific roles for any of these resources being used in this plan. Letters of support are attached to this plan as Appendix 3.

The State's ability to coordinate funding streams for bioterrorism related programs, specifically those coming from HRSA, CDC and the DHHS Office of Emergency Preparedness (OEP), into a single well-integrated vision and operational plan:

DOH has implemented plans to fully coordinate the funding streams for Washington State bioterrorism related programs through the establishment of the Statewide Bioterrorism Response Advisory Committee and the Bioterrorism Hospital Preparedness Program Committee, and through DOH membership on the Washington State

Emergency Management Council and the Committee on Terrorism.[38] Also please see section immediately below.

Coordination with other State or Federal funding sources being used in this plan:

Coordination with other state and federal funding sources is accomplished through the oversight and coordinative review and assessment of all Washington State bioterrorism and disaster planning activities by the Governor's Committee on Emergency Management and its Committee on Terrorism, and their member and constituent organizations. The Governor has charged the EMC and COT with coordinating Washington State bioterrorism and disaster programs and activities. This plan and its content must be reviewed and approved by these Committees prior to submission to the Governor for final approval.

The bioterrorism preparedness plan interfaces with local, regional and State preparedness plans for other types of disasters.

The DOH Bioterrorism Preparedness and Response Plan* is designed to provide the primary Washington State program framework and guidance for state and local response to bioterrorism incidents, as a major portion of the statewide preparedness response plans for bioterrorism, natural or man-made disaster, WMD, chemical, or other mass casualty incidents. The DOH plan has been developed in cooperation and coordination with the Washington Committee on Terrorism, charged by the Governor with developing the statewide strategy for preventing, planning, and responding to threats and acts of terrorism, and with providing a forum for general coordination and the exchange of information among federal, state, and local entities regarding bioterrorism and disaster issues. The DOH plan has been developed specifically to support and coordinate the response to bioterrorism incidents within the state through establishing a framework to implement, support, and provide guidance for local and regional bioterrorism response plans in the hospital and prehospital areas. In that context, the plan will support and buttress the other disaster-response planning and response activities in Washington as specified in local and regional biological and disaster first response plans. An organizational chart is attached as Appendix 1.

[38] CDC – HRSA Coordination, see Focus Area A

3. System Development: Justification of costs attributable to planning, coordination and infrastructure for the State health department, outside organizations, and local hospitals, outpatient facilities and EMS systems: Please refer to Section H, "Budget" and Appendix 4.

Sustainability of the preparedness plan (other funding sources, in-kind resources, integration into existing programs):

Sustainability of the hospital bioterrorism preparedness effort has been a primary goal in the development of the state plan. Areas such as training, which have an ongoing need for funding as new personnel, equipment, and training content become integral parts of the response system in place, will need to be incorporated as much as possible into first responder and clinician education and training programs. In general, much of the sustained cost of non-subsidized ongoing operation and incremental technological improvements in the local and state response systems will be addressed by the local and state entities that are responsible for their operation, in the absence of continued and ongoing federal support for their operation.

The financial planning process to maintain a State of preparedness if the Federal funding in this grant is no longer available in subsequent years:

The institutions, agencies, and entities at the local and state levels that have responsibility for ongoing preparedness and response would undertake financial planning and provisions for maintenance of effort in the absence of federal funding. These agencies and entities would undoubtedly seek required support through their local and state political processes but a positive outcome in this area cannot be predetermined.

4. Legislation and Regulation: State statutes, regulations and ordinances that may impact a timely and complete response to terrorism:

Under Washington statute, the governor and leadership of political subdivisions can impress (commandeer) the citizenry to respond to an emergency if the governor issues an emergency proclamation. Consequently, in Washington State the appropriate state and local authorities would under statute be able to take action to protect the public health and safety as required, but the implementation plan for that action is lacking. For example, under Washington statute local health officers could quarantine or isolate individuals, but the process and enforcement authority under the statute have not been spelled out. DOH is proposing, in

conjunction with the Attorney General's Office and as part of the CDC Bioterrorism Proposal[39] development process, a review during FY '03 of current legislation and rule to specify and clarify all process and enforcement issues, as well as undertake a review of local ordinances and codes addressing those issues as well.

Solutions to these barriers that will be pursued by the State EMS agency and other components of State government:

Resolution of any professional or facility regulatory barriers impacting a timely and complete response to terrorism will be addressed by the appropriate DOH regulatory division or office through its rulemaking process; The Office of Health Professions Quality Assurance (HPQA) for the medical, nursing, and associated healthcare professions; Office of Emergency Medical and Trauma Prevention for First Responders, EMTs, and Paramedics; and FLS for hospitals and other healthcare facilities. Any statutory barriers will be addressed through consultation between the affected regulated entities and associations, and the responsible division or office of the DOH, followed by the development and introduction of appropriate corrective/implementing legislation in the Washington State Legislature during the '03-'05 Legislative Session.

G. Letters of Support: Letters of support are attached as Appendix 3.

These document the collaboration described in the application. Collaborating agencies include:

- *State hospital association*
- *State EMS regulatory agency or advisory board*
- *State rural health office*
- *State office of emergency management*
- *Tertiary care centers serving as referral facilities or centers of excellence for bioterrorism incidents. Letters must be obtained from all such centers that are integrated into the State's bioterrorism plan.*
- *Other organizations being used as resources in bioterrorism preparedness*

H. Budget: *An updated budget and justification for Phase 2*:

The budget for this proposal is attached as Appendix 4.

[39] CDC – HRSA Coordination, see Focus Area A

I. Data Collection, Quality Improvement and Reporting

The plan provides for progress reports on measurable objectives.

Washington's plan will provide for progress reports on measurable objectives. A regional data collection system intended to foster regional partnerships will be integrated into a future developed state-level report. As envisioned, the regional data collection system will gather information on hospital needs assessments. Where needs assessments have been completed, the system will gather information regarding how these needs have been addressed. Through the amendment of existing regional EMS and Trauma Care Council contracts, hospitals will provide monthly reports to the EMS and Trauma Care Councils. The EMS and Trauma Care Councils will work to ensure reports are completed and then submitted to the DOH Hospital Bioterrorism program for compilation and quarterly reporting to the Bioterrorism Hospital Preparedness and Planning Committee. Semiannual reports will be produced as a result of the information received from this regional data collection system.

It is expected that these regional reports will also serve to assist the regions in annually updating their regional plans. These regional plans help ensure local, regional and state needs are continually monitored and addressed in order to maintain a viable response system at each of these levels. This regional model of data collection, quality improvement and reporting builds upon Washington's existing system of regional trauma care delivery. By utilizing this existing regional model, updates to the initial needs assessments and revisions to future plans are easily accomplished through current DOH regional contracts. Amendments to the regional contracts can occur quickly and efficiently once a report template is designed with approved data elements.

Appendix I

Governor's Domestic Security Infrastructure

Appendix II

Work Plan Timelines

HRSA

B. Needs Assessment/Hospital

Work Plan Timeline

Needs Assessment	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
	Prepare a plan for assessment of unmet needs the state has in order to be able to implement a hospital and EMS bioterrorism response	Review existing hospital and EMS related disaster preparedness surveys/assessment	Hospitals, Primary Care, EMS, Emergency Management, Rural Health, Veteran Affairs, Military Hospitals, LHJ's, Fire, Indian Affairs, L&I	Convene Hospital BT Committee meeting to review existing surveys/assessments	5/02
		Develop Assessment Tool based on identified gaps/deficiencies of previous assessments. Include following assessments: Need for bioterrorism plan that addresses triage, isolation, quarantine, decontamination, stabilization, treatment and referral of multiple casualties (whether presenting all at once or gradually over time) Need for reconfiguration of hospital space for quarantine of communicable diseases and treatment of infectious disease epidemics, including provision of security services. Need for personnel augmentation (physicians, nurses, pharmacists, mental health professionals and others) to handle large influxes of patients. Need for licensing, credentialing and supervision of clinicians not normally working in facilities responding to a bioterrorist incident.	Same as above	DOH/WSHA develop assessment tool Determine assessment scope, coordinate with CDC group to identify redundancies Ensure Hospital BT Committee reviews and approves	5/02-6/02

Needs Assessment	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
		Need for mechanisms to manage unsolicited clinical help and donated items. Need for protection of clinicians (vaccination, antibiotic prophylaxis, personal protective equipment, education) to ensure their availability in an epidemic. Need for training in recognition of rare diseases with bioterrorism potential. Need for diagnostic and treatment protocols addressing bioterrorist infectious diseases with early nonspecific syndromes, and for mechanisms to bring clinicians up to speed on these protocols before and during a bioterrorism event. Need for pharmaceuticals and vaccines for patients or exposed individuals. Need for children, pregnant women, the elderly and those with disabilities. Need for infrastructure and collaboration between hospitals and EMS systems that support effective diversion and referral plans Need for identification of emergency departments and outpatient centers capable of initial assessment and treatment of biological exposures Need for linkages to sources of expert consultation and referral centers capable of addressing biological exposures definitively (such as communicable diseases isolation facility that can serve as the dedicated referral hospital for CDC's Division of Global Migration and Quarantine) Need for delivery to facilities and individual			

Needs Assessment	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
		casualties of essential goods and services such as food, water, shelter and electricity. Any existing gaps in objective data that inhibit planning. Needs for technical assistance from the HRSA Bioterrorism Hospital Preparedness Program or its contractors.			
		Implement Needs Assessment Tool	Same as above	Conduct assessment and compile results	6/02-7/02
		Analyze Data Results	Same as above	Review results Present to Hospital BT Committee for discussion on integrating any pertinent results into model regional hospital plan Prioritize Needs Consider budgetary implications funding distribution methods	7/02- 8/02

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C. Critical Benchmark(s) #1,2,3:
Hospital Program Direction, Hospital Committee, Regional Hospital Plans

Work Plan Timeline

Capacity or Bench-mark #	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
1.	Designate Coordinator for Bioterrorism Hospital Preparedness Planning.	Describe coordinator duties to include curriculum vita	Hospitals, EMS, emergency management,	Identify Bioterrorism Coordinator and support staff	April 15 2002
2.	Establish Hospital Preparedness Planning Committee	Meet at least once during planning phase, quarterly during implementation phase to provide guidance, direction and oversight to DOH	Hospitals, Primary Care, EMS, Emergency Management, Rural Health, Veteran Affairs, Military Hospitals, LHJ's, Fire, Indian Affairs, L&I	Develop BT Hospital Committee Charter Provide current roster of planning committee and rationale for inclusion of each member	April 15 2002
3.	Develop regional hospital plans to respond to a potential epidemic involving at least 500 patients	Establish an approach to the development and implementation of regional hospital plans for a large-scale epidemic Coordinate review and sign off by local health officer	Hospital BT Committee, Statewide BT Committee, LHJ, regional LHJs, regional EMS Councils	Convene meeting of Hospital BT Committee to review literature on best practices/models for hospital disaster response plans Ascertain quality of existing hospital disaster response plans, identify gaps and deficiencies	May 2002
		Develop a Model Regional Hospital Preparedness Plan integrating the	Same as above	Convene regional hospital plan development committee to create model hospital	June 2002-Sept

Capacity or Bench-mark #	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
		following elements: Plan for increasing hospital bed capacity to accommodate increases in admissions from an infectious disease epidemic over an extended period of time. Plan for providing isolation and quarantine for casualties, using such references as CDC's for Type C (contagious) facilities Plan to address overcrowding and need for hospital diversion, with large numbers of acute causalities arriving on their own or by ambulance, including a rapid communication plan with EMS units that allow them to determine a destination immediately at any time. Plan for how hospitals will receive patients on a daily bases when several hospitals are on diversion simultaneously. Plan for ensuring movement of equipment maintained by hospitals or EMS systems to the scene of a bioterrorist event. Plan for how the special needs of children, pregnant women, the elderly and those with disabilities will be addressed in ensuring access to medically appropriate care. Plans to include school settings and the clinicians caring for them there. Plan for how essential goods and services such as food, water, electricity and shelter will be delivered to patients and hospitals. Plan for how hospital security will be provided (crowd control, patient traffic to		bioterrorism response plans which can be adapted within a rural, suburban and urban setting and serve as a guidance document for regional hospital BT plan development Coordinate with CDC group to identify redundancies or additional questions Coordinate and integrate needs assessment results with planning efforts	2002

Capacity or Bench-mark #	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
		support triage decisions, prevention of further terrorist attacks at the hospital. Plan for procedures for safe and appropriate disposal of medical waste.			
		Contract with Regional EMS & Trauma Care Councils to coordinate and write regional hospital bioterrorism response plans	Same as above	DOH to provide Regional EMS and Trauma Care Councils with model hospital bioterrorism regional guidance as basis for writing final regional hospital bioterrorism response plans Obtain signature of BT Hospital Committee on final plans	Sept 02 to February 03
		Implementation of Regional Hospital Bioterrorism Plans	Same as above	Conduct Tabletop Exercises with regional response plans Collaborate with CDC planning and exercise efforts	March 03
		Revise Regional Hospital Plans based on input from tabletops	Same as above	Collaborate with CDC planning efforts	April-June 03
		Complete initial drafts of Regional Hospital Plans	Same as above	Collaborate with CDC planning efforts	August 03

D. First Priority Planning Areas:

Work Plan Timeline

Capacity or Bench-mark #	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
FPPA (1)	Develop plan to make short-term (1st 48 hours) antibiotic and vaccine treatment available statewide	MOUs between DoH and pharmaceutical cache owners and MMRs cities regarding short-term stockpiling and distribution of antibiotics and vaccines	DOH, LHJs, MMRS cities, pharmaceutical cache owners	Agreement and implementation of MOUs between parties	9/15/02
FPPA (1)	Finalize plan to receive and distribute federal antibiotic and vaccine resources (CDC push packs) re: biological exposure	Official approval of WA state NPS plan.	DOH, Governor's Office	Completion and approval of state NPS plan	7/30/02
FPPA (1)	Create biological/disaster incident vaccination clinic operation template for inclusion in WA NPS plan	Identify required content for vaccination clinic operations, including pharmaceutical and staffing requirements	DOH, LHJs, CDC	Approval of vaccination clinic operational template	7/30/02
FPPA (2)	Develop plan to protect clinicians and their families from biochemical casualties and environments	Identify resources and procedures required to provide appropriate protection	DOH, LHJs, Hospitals, EMS	Clinician protection plan implemented	12/30/02
FPPA (2)	Prepare plan to upgrade existing hospital facility decontamination systems, including specifying facilities and identifying required capital improvements	Conduct risk assessment to determine appropriate facilities for upgrades and capital improvements, and determine minimum PPE requirements	DOH, LHJs, hospitals, WSHA	Facilities identified for upgrades and capital improvements, and implement funding plan for system improvements including securing required PPE	1/30/03

Capacity or Bench-mark #	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
FPPA (2)	Develop plan regarding benefits and cost-effectiveness of deploying additional decontamination equipment (mobile caches, etc.)	Conduct assessment of location and condition of current equipment, develop list of required equipment, review specific local requirements for particular equipment, and determine appropriate deployment methods	DOH, hospitals, EMS, LHJs, EM agencies, WSHA	Appropriate decontamination equipment deployment methodology determined, as required	1/30/02
FPPA (3)	Develop plan to activate (re: communications issues) state bioterrorism preparedness program during an acute epidemic incident	Conduct a statewide bioterrorism system activation training exercise to determine current weaknesses, and implement required changes in activation system based on drill	DoH, hospitals, local and regional EMS, LHJs, EM agencies, law enforcement, fire agencies	Conduct system activation exercise	2/28/03
FPPA (3)	Develop plan to address gaps in emergency communications systems relating to bioterrorism response	Conduct integrated assessment of emergency communications system, review system gaps, and determine requirements for completing statewide communications system	DoH, hospitals, local and regional EMS, LHJs, EOC, EM agencies, law enforcement, fire agencies	Completion of assessment	10/31/02
FPPA (3)	Develop plan to assure communication system redundancy	(see above)	(see above)	(see above)	10/31/02
FPPA (3)	Implement plan for electronic tracking of statewide bed status, and monitoring ED status	Conduct review of current web-based tracking methodology	DoH, hospitals, LHJs	Completion of review, and assessment of current status of tracking methodology	9/30/02
FPPA (3)	Implement public relations plan re: large numbers of patients, worried well, family, friends, and media.	Review current public relations plan	DoH	Completion of review and assessment of current plan	6/30/02

Capacity or Bench-mark #	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
FPPA (4)	Develop state plan for testing state and local bioterrorism response plans (drills), including intensity level	Conduct a bioterrorism incident response tabletop exercise in each county Ensure local health officer reviews and signs-off	DoH, hospitals, local and regional EMS, LHJs, EOC, EM agencies, law enforcement, fire agencies	Tabletop exercise conducted in each county, identifying gaps in response and county plans	3/15/03
FFPA (4)	Develop plan for incorporating lessons learned from drills into regular revisions of state and local bioterrorism plans	Drill participants determine lessons learned and jointly determine actions required to incorporate into response plans	DoH, hospitals, local and regional EMS, LHJs, EOC, EM agencies, law enforcement, fire agencies	Actions taken to incorporate lessons learned into state and local response plans	3/15/03

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E. Second Priority Planning Areas:

Work Plan Timeline

Capacity or Bench-mark #	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
SPPA (1)	Develop EMS and hospital personnel recruitment and deployment plan, per HRSA specifications (50/20)	Meet with health care professional associations and organizations re: plan development, and review state and local disaster response plans re: activation procedures (incl. MMRS and DMAT recruitment and deployment)	DOH, state HC assns and orgs, hospitals, EMS, EM agencies	Implement additional health care professionals recruitment and deployment plan	6/30/03
SPPA (1)	Develop plan for ensuring hospital and EMS support thru mutual aid agreements, MMRS, and/or DMATs	Identify current mutual aid agreements, draft model mutual aid agreement(s), and determine need for additional/revised mutual aid agreements, including legislative issues Ensure coordination with and sign-off by local health officer	DOH, EMS, LHJs, hospitals, MMRS, DMATs, HC assns and orgs.	Begin implementation of model mutual aid agreements statewide, and develop draft legislation for state EMS Mobilization Plan	9/30/03
SPPA (1)	Develop plan for reciprocity, credentialing, and supervision of clinicians during incident	Identify issues for resolution regarding reciprocity, credentialing, and supervision, and determine specific activities required to clarify and resolve those issues	DOH, state HC assns and orgs, hospitals, EMS, EM agencies, others	Issues identified and plan implemented to address reciprocity, credentialing, and supervision issues	12/30/03
SPPA (2)	Improve training delivery capacity, and access resources, for hospital and EMS clinicians	Identify issues and resources re: training delivery capacity, including human resources, technology, and funding requirements, and development of plan to address these issues	DOH, state HC assns and orgs, hospitals, LHJs, EMS, local and regional EMS councils	Implementation of training capacity enhancement program statewide	12/30/03

Capacity or Bench-mark #	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
SPPA (2)	Develop plan for updating bioterrorism disease and toxin treatment protocols, including for special needs populations, and for enhancing poison control center response capabilities	Review current hospital and prehospital protocols, and meet with affected groups to review and update protocols as required.	DOH, state HC assns and orgs, LHJs, hospitals, EMS, local and regional EMS councils, special needs groups, Poison Control Center		12/30/03
SPPA (2)	Develop plan for ensuring meeting continuing CME needs on bioterrorism issues, including links to national/military resources	Review current CME content and determine need for new/expanded content on bioterrorism, focused on current "best practices" models and on-going national and military bioterrorism education development	DOH, state HC assns and orgs, hospitals, EMS, local and regional EMS councils	Implementation of updated/expanded CME content for health care professionals	3/15/04
SPPA (3)	Develop plan for hospital evacuation, patient triage, EMS transport of patients, and alternative (non-hospital) housing for patients during bioterrorism incident, including special needs populations	Conduct assessment of current hospital requirements/plans re: patient handling and housing issues during bioterrorism incidents, including special needs patients Ensure coordination with and plan sign-off by local health officer	DOH, state HC assns and orgs, hospitals, LHJs, EMS, local and regional EMS councils	Establish model for hospital plans re: patient handling and housing issues	1/30/04
SPPA (3)	Develop plan for integration, at local levels, of school buildings and staffs into biological incident response system	Review current state and local plans regarding use of buildings and staff during bioterrorism or disaster incident Ensure coordination with and plan sign-off by local health officer	DOH, OSPI, state HC assns and orgs, hospitals, EMS, local and regional EMS councils, LHJs, state educational associations, local EM agencies, local schools	Draft model plan for utilization of school buildings and staff during biological or disaster incident	3/15/04

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F. Infrastructure

Work Plan Timeline

Capacity or Bench-mark #	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
1	Describe how medical expertise will be included in developing the BT preparedness plans.	Determine key partners and stakeholders for plan review and regional plan implementation	WSMA-Disaster Preparedness Committee, EMS Standards Committee, WSHA, County Physician Medical Program Directors CDC	Routinely include partners, Hospital BT Committee, and statewide BT Committee in review of regional hospital preparedness plans primarily through the use of e-mail. At least annually provide direct report to WSMA Disaster Preparedness & EMS Standards Committee and County physician medical program directors Seek monthly consultation from state BT medical director	5/02 through 3/15/04 (ongoing) 06/03 and annually thereafter 04/02 through 3/15/04
1	Discuss role of medical director in providing guidance to the BT preparedness program	Seek input from WSMA and WSHA on job description	WSHA, WSMA	Write medical director job description Hire .25 medical director	4/15/02 5/02
1	Discuss role of state EMS director in BT hospital preparedness.	Seek input from state EMS director	State EMS, Regional EMS & Trauma Care Councils	Describe state EMS director role Member Hospital BT Committee for system development guidance Guide planning and implementation capabilities of the regional EMS councils	4/15/02 Ongoing Ongoing
1	Discuss support staff role in administering cooperative agreement	Seek input DOH, WSHA	WSHA	Write job descriptions, identify roles and responsibilities Hire Hospital Bioterrorism Coordinator Hire HCS3	4/1/502 4/15/02 4/15/02

Capacity or Bench-mark #	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
2	Discuss Coordination and Collaboration of partners and stakeholders	Seek input from BT Hospital Committee on phase 2 application	Hospitals, Primary Care, EMS, Emergency Management, Rural Health, Veteran Affairs, Military Hospitals, LHJ's, Fire, Indian Affairs, L&I	Convene BT Hospital Committee meeting Seek input from CDC focus group and share phase 2 draft electronically with BT Hospital Committee, CDC focus group Include organization chart of state, local and regional efforts to collaborate	3/25/02 3/22-4/1/02 4/15/02
2	Address how state will coordinate funding streams from HRSA, CDC, OEP into integrated plan	Seek input from CDC focus workgroup	DOH	Coordinate planning efforts with CDC workgroup during grant application process and after through sharing of information at BT Hospital Committee, Statewide BT Committee, and with DOH Special Assistant	4/15/02 ongoing to 3/15/04
2	Discuss coordination with other State or Federal funding sources in the plan	Coordinate plan development with state Emergency Management, and Region 10- Office of Emergency Preparedness	Hospitals, Primary Care, EMS, Emergency Management, Rural Health, Veteran Affairs, Military Hospitals, LHJ's, Fire, Indian Affairs, L&I	Convene quarterly meetings of the Hospital BT Committee to ensure state and federal collaboration of funding sources Maintain communication link with state BT Committee, the Committee on Terrorism, and 3 MMRS cities	5/02 ongoing to 3/15/04 5/02 ongoing to 3/15/04
2	Discuss how bioterrorism plan interfaces with local and regional preparedness plans for other types of disasters	See narrative---all hazards Coordinate with local health officer on plan review and sign-off	Hospitals, Primary Care, EMS, Emergency Management, Rural Health, Veteran Affairs, Military Hospitals, LHJ's, Fire, Indian Affairs, L&I	Regional Hospital Plan template to include guidance to regions on building plans beyond biological response	9/02 to 2/03
3	System Development:Costs attributable to planning,	Identify approximate costs for: plan development, operational protocols,	Hospitals, Primary Care, EMS, Emergency Management, Rural Health, Veteran Affairs,	BT Hospital Committee review proposed costs	3/25/02

Capacity or Bench-mark #	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
	coordination and infrastructure for state health department, outside organizations, and local hospitals, outpatient facilities and EMS system.	policies and procedures, travel necessary to meet with collaborating entities, expenses to attend professional conferences	Military Hospitals, LHJ's, Fire, Indian Affairs, L&I		
3	Discuss sustainability of preparedness plan (other funding sources, in-kind resources, integration into existing programs	Use existing infrastructure to maintain plan updates and the	DOH, EMS regions, LHJ's	Seek guidance from BT Hospital Committee, CDC work group, DOH	3/15/04
3	Describe the financial planning process to maintain a State of preparedness if Federal funding in this grant is no longer available in subsequent years.		DOH		
4.	Legislation and Regulation	Address laws which may impact timely response to terrorism Discuss solutions to barriers	DOH, CDC focus group Legislature, AGO, state Board of Health	Seek guidance from CDC focus group Work with DOH and appropriate divisions to address legal issues and barriers	4/15/02 5/02 ongoing

HRSA

I. Hospital Program-Data Collection, Quality Improvement and Reporting

Work Plan Timeline

Capacity or Bench-mark #	Objective (Improvement)	Activity	Partners	Milestone Measures	Due Date
	Describe the plan for progress reports on measurable objectives to include a local data collection system that can be integrated into a standardized state-level report	Build upon existing regional infrastructure to collect data Amend regional contracts	Hospitals, Primary Care, EMS, Emergency Management, Rural Health, Veteran Affairs, Military Hospitals, LHJ's, Fire, Indian Affairs, L&I Regional EMS Councils	Develop plan for hospital submission of data to regions and then roll up to state Develop simple reporting template and determine reporting frequency (monthly vs. quarterly?) Implement data collection program Provide semiannual report to HRSA	5/02 6/02 5/02 to 6/02 7/02 ongoing to 3/15/04

Appendix III

Letters of Support

HRSA –Letters of Support Listing:
Letters of support for the planning proposal, "Bioterrorism Hospital Preparedness Program":

-Washington State Hospital Association
-DOH/Office of Emergency Medical and Trauma Prevention
-Washington Association of Community and Migrant Health Centers
-Washington Military Department/Emergency Management Division
-DOH/Office of Community and Rural Health
-Department of Veteran Affairs
-Department of the Army/Madigan Army Medical Center
-Association of Washington Public Hospital Districts
-Washington State Nurses Association
-Washington State Council of Fire Fighters
-Kitsap County Department of Emergency Management
-Spokane Regional Health District
-Thurston County Public Health and Social Services Department
-Governor's Office of Indian Affairs
-Department of Labor and Industries

Appendix IV

Budget & Financial Narrative

HRSA Hospital Bioterrorism Preparedness

Budget

Salaries	127,008.
Benefits	30,482.
Travel	27,485
Equipment	0.
Contractual	1,723,000.
Supplies	19,050.
Other	27,250.
Sub-Total	1,954,275.
Indirect costs	72,099.
Total	2,026,374.

A Short Budget Narrative

The purpose of these funds is to review and assess gaps and deficiencies in current Washington hospital capacities to respond to bioterrorism and other disaster incidents, and to develop regional hospital response plans to improve Washington hospital response capacity. The activities are divided into the following areas:

Personnel: 127,008.

Personnel costs associated with this activity include a Bioterrorism Hospital Preparedness Coordinator to manage the DOH Bioterrorism Hospital Preparedness Program, and a Health Services Consultant 3 to provide technical assistance to hospitals and regional Emergency Medical Services and Trauma Care councils re: completion and submission of hospital assessments and development of regional hospital plans.

Position	Annual Salary	Currently Funded	FTE	FTE Authority
Bioterrorism Hospital Preparedness Coordinator	69,756.	No	1.0	New
Health Services Consultant 3	57,252.	No	1.0	New

Benefits: 30,482.
Benefits are calculated at 25% of the salaries listed above.

Travel: 27,485.
Travel costs consist of staff and advisory committee member travel, including privately-owned vehicle mileage reimbursement, in-state flights, in-state lodging, per-diem, and out-of-state travel associated with required meetings and conferences with federal and other state officials regarding Washington's Bioterrorism Hospital Preparedness Plan.

Supplies: 19,050.
The expenditure for supplies includes standard office supplies, paper, desktop software, and other normal office supply costs associated with supporting the activities of the personnel identified above.

Contract under $20,000.: 0.

Contract over $20,000.: 40,000.
Contract for Medical Consultant (M.D. with specialized bioterrorism/disaster experience) at .25 FTE, per contract requirement to obtain medical expertise in developing and implementing the state bioterrorism preparedness plan.

Pass-Thru Contracts: 1,683,000.

Hospital Bioterrorism Assessment: 1,463,000.

These contracts are for $15,400. each, for 95 hospitals. Under these contracts each hospital in the state will assess their existing facility needs and determine gaps and deficiencies regarding their capacity and preparedness to respond to bioterrorism and disaster incidents. The results will be then used in determining hospital needs to improve response capacity.

Regional Hospital Plan Development and Data Collection: 220,000.

These contracts are for $27,500. each, for eight regional EMS and trauma care councils. Under these contracts each regional council will coordinate the development of the regional hospital response plans, above, based on the results of the individual hospital needs assessments. This will include providing a regional data collection, collation, and reporting function to DoH regarding the hospital needs assessments and gap determinations.

Other: 27,250.

This expenditure includes workstations and computer, two laptop computers and boxlights, additional equipment costs, including network interfacing, IS support and training, and required software licenses.

Indirect Costs: 72,099. (Total)

DOH – Health Services Quality Assurance (22.2%): 51,423.

Pass-Thru and Contract over 20,000.: 20,676.

Appendix V

Phase I Budget

Phase 1 – Bioterrorism – Hospital Preparedness Program
Budget Narrative

Personnel $ 39,675

Person	Annual Salary	FTE	Total
Bioterrorism Hospital Preparedness Program Coordinator – 1 FTE (estimated as 0.25 FTE for the three-month period March 1 – May 31, 2002. Senior level Washington Management Service corps person. Salary estimated as equivalent to State Civil Service grade 66	$ 69,756	0.25	$ 17,439
Bioterrorism Health Services Consultant 3 – 1 FTE (estimated as 0.25 FTE for the three-month period March 1 – May 31, 2002. Intermediate level Washington Management Service corps person. Salary estimated as equivalent to State Civil Service grade 55	$ 53,136	0.25	$ 13,284
Secretarial Support– 1 FTE (estimated as 0.25 FTE for the three month period March 1 – May 31, 2002. Senior level administrative and secretarial support. Salary estimated as equivalent to State Civil Service grade 39	$ 35,809	0.25	$ 8,952

Fringe Benefits

Estimated at 24% of Salaries $ 9,522

Travel $ 17,845

Three (3) meetings of the State-Wide Hospital Bioterrorism Preparedness Planning Committee are planned. Budget estimate includes one-day travel for members from both Eastern and Western Washington State.

Additional travel cost included for travel by some state staff members to hospital, and local health jurisdiction offices in Eastern and Western Washington State.

Supplies $ 22,250

Two new complete workstations with furniture and computer installation. Third FTE is an existing employee and will not need new equipment.

Direct FTE associated costs (paper, communications, rent, utilities, etc.)

Pass-Through Contracts $ 390,554

Three major contracts

1) Funding to begin the statewide enhancement of the Washington Emergency Medical Radio System (WEMRS) to increase the regional communication infrastructure between hospitals, local health jurisdictions, police, fire, EMS, local and state emergency operating centers. - $120,000

2) Funding to begin the statewide expansion of the Puget Sound Hospital Capacity Website which features hospital bed capacity, emergency department status, patient tracking and weapons of mass destruction pharmacologicals by enhancing the system hardware capability and extensive training in data entry and system's use. - $ 45,554

3) Level "C" Biohazard suits – With the goal of placing level "C" suits in every hospital, begin the initial purchase of at least 150 suits with guidance from the State-Wide Hospital Bioterrorism Preparedness Planning Committee for decisions regarding the appropriate facility placement of the biohazard suits. Initial purchase of 150 suits at approximately $1,500 per suit to include training- $225,000

Other $ 1,905

Three State-Wide Hospital Bioterrorism Preparedness Planning Committee meeting room rentals (estimated at $250 per meeting for short notice facility rental) – expected attendance is 25 persons – 15 Committee Members and up to 10 state staff)

Other cost incidental to meeting with Local Health Jurisdictions and hospitals by state staff member in Eastern and Western Washington

Indirect costs $ 24,933

The currently approved (DHHS) indirect rate of the Office of the Secretary is 22.20 %. Modified Total Direct Costs for which this rate is applicable sum to $ 91,197. Applicable indirect cost is $20,246.

The currently approved (DHHS) indirect rate for Pass-Through costs and Contracts over $20,000 is 1.2 %. Modified Total Direct Costs for which this rate is applicable sum to $ 390,554. Applicable indirect cost is $4,687

Total indirect costs of $24,932 are 4.92 % of the requested award, which is under the 10% limit stated in the program guidance.